

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14043

14011

|   |                                      |  |  |
|---|--------------------------------------|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>   |                                      | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>              |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda (Rural)</u>   |                                      | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>S. Arlington</u> <u>83X-3</u>                                     |  |
| c. LENGTH OF STAY IN 1b<br><u>8 days</u>  |                                      | d. STREET ADDRESS<br><u>4614 6th Street</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>U. S. Naval Hospital</u>   |                                      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First <u>Edith</u> Middle <u>M</u> Last <u>Ailes</u>   |                                      | <b>4. DATE OF DEATH</b><br>Month <u>December</u> Day <u>6</u> Year <u>19 61</u>  |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>Caucasian</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 27, 1907</u> <u>54</u> yrs. |
| 9. AGE (In years last birthday)<br><u>54</u> yrs.   |                                      | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  |
| 10a. KIND OF BUSINESS OR INDUSTRY<br><u>Pennsylvania</u>  |                                      | 11. BIRTHPLACE (County & State, or foreign country)<br><u>USA</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |                                      | 13. FATHER'S NAME<br><u>Alfred H. McLantire</u>  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Clara Hudson</u>   |                                      | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>                                     |  |
| 16. SOCIAL SECURITY NO.<br><u>Hospital Records</u>  |                                      | 17. INFORMANT<br><u>Hospital Records</u>   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma of lung</u><br>DUE TO <u>162-1</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>162-1</u><br>(c) <u>162-1</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>162-1</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> |                                      |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                      |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>   |                                      |  |  |
| <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |                                      |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>19</u>   |                                      |  |  |
| <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                      |  |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |                                      |  |  |
| <b>20f. (City or town) (County) (State)</b>   |                                      |  |  |
| <b>21. I certify that (1) (this hospital) attended the deceased from <u>Nov. 27, 1961</u> to <u>Dec. 6, 1961</u> that (2) (we) last saw the deceased alive on <u>Dec. 6, 1961</u>, and that death occurred at <u>7:58 AM</u> from the causes and on the date stated above.</b>  |                                      |  |  |
| <b>22a. SIGNATURE</b> <u>Robert E. De Forest</u> M.D. <b>22b. DATE SIGNED</b> <u>December 6, 1961</u>   |                                      |  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b> <u>ROBERT E. DE FOREST LT MC USN</u> <b>22d. ADDRESS</b> <u>U. S. Naval Hospital, Bethesda, Md.</u>   |                                      |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>   |                                      | <b>23b. DATE THEREOF</b><br><u>12-11-61</u>  |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Arlington National</u>  |                                      | <b>23d. LOCATION (City, town or county) (State)</b><br><u>Arlington, Virginia</u>  |  |
| <b>24a. REC'D BY REGISTRAR</b><br><u>Arthur S. Hume</u>   |                                      | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Hume</u>   |  |
| <b>24b. ADDRESS</b><br><u>Arlington Funeral Home, Arlington, Va.</u>  |                                      | <b>25a. DATE</b><br><u>DEC 8 '61</u>   |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14012

1  
FOR STATE  
HEALTH DEPT.

any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3-Page 5 may be retained for your files. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Howard</u>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenwood</u>   |  |
| c. LENGTH OF STAY IN 1b <u>20 A.</u>   |   | d. STREET ADDRESS <u>Dorsey Mill Rd</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery Gen. Hosp</u>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Charles Edward Anderson</u>   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>Dec 22 1961</u>   |  |
| 5. SEX <u>male</u>   | 6. COLOR OR RACE <u>col</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Month Day Year<br><u>10-6-61</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |   | 11. BIRTHPLACE (State or foreign country) <u>Ind</u>   |  |
| 10b. KIND OF BUSINESS OR INDUSTRY  |   | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME <u>Vernon Anderson</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Rosalie Bell</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <u>Rosalie Anderson (mother)</u>   |   | Address <u>Stn 2</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br>DUE TO (b) <u>suppur Respiratory Infection</u><br>DUE TO (c) <u>Asphyxia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                 |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u>   |   | DATE SIGNED <u>12-22-61</u>  |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |   | 22b. DATE THEREOF <u>12-23-61</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Louis</u>  |   | 22d. LOCATION (City, town, or country) (State) <u>Clarksville, Md</u>  |  |
| 23. FUNERAL DIRECTOR ADDRESS <u>F.C. Higinbotham, Ellicott City, Md</u>  |   | 24a. REC'D BY REGISTRAR <u>DEC 26 '61</u>  |  |
|  |   | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14045

CERTIFICATE OF DEATH

14013

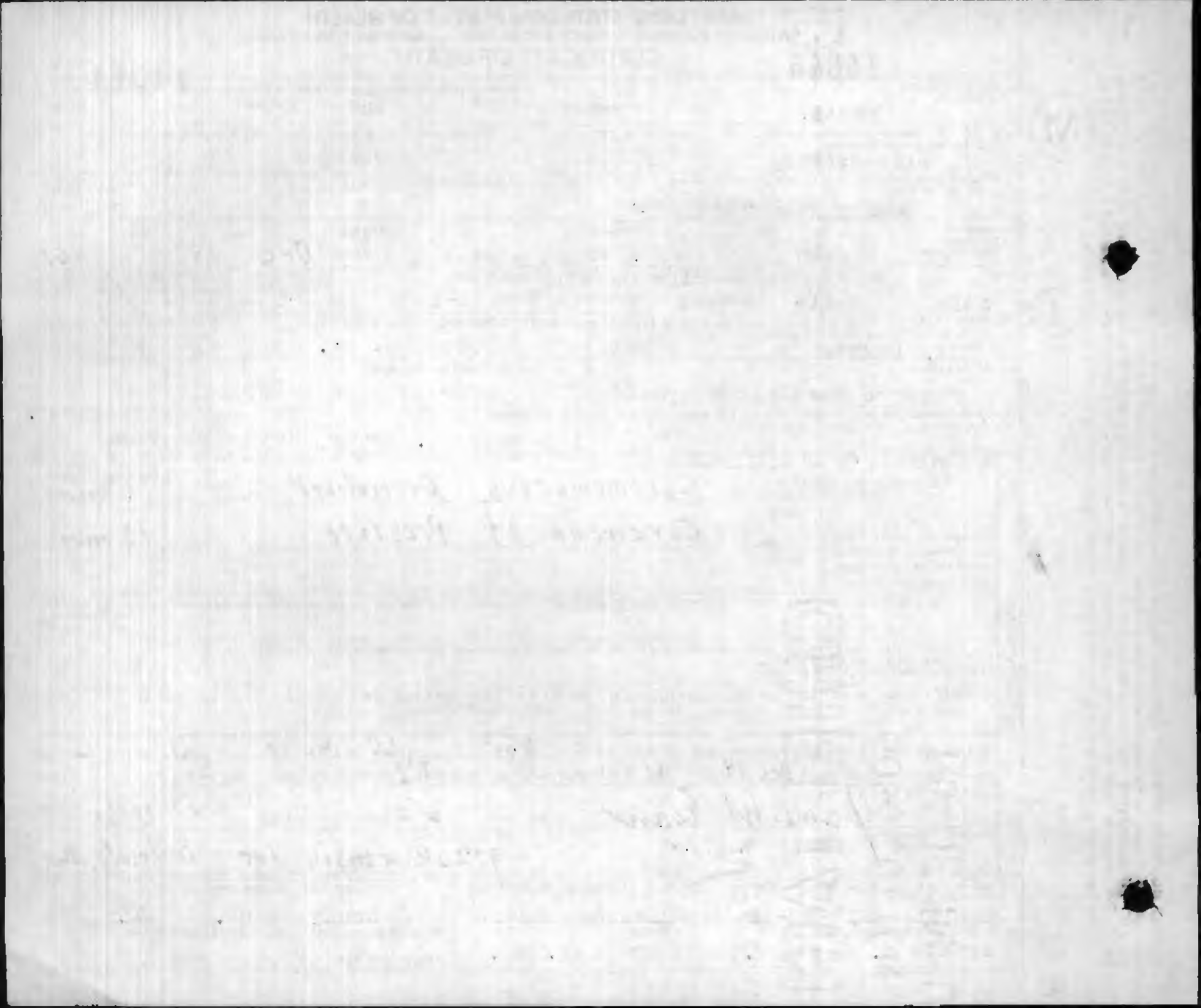
|   |  |   |  |  |  |   |  |   |  |  |  |   |  |  |  |                  |  |
|---|--|---|--|--|--|---|--|---|--|--|--|---|--|--|--|------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San &amp; Hospital</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 28</u><br>d. STREET ADDRESS <u>2001 Hanover St S.I.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |  |  |   |  |  |  |                  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Walter Andrew Anderson</u>  |  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>4</u> Year <u>1961</u>                                       |  | 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>April 17-1889</u> 72 yrs.   |  | 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |  |  |  |                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - office worker</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Brooklyn</u>  |  |   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>   |  |  |  |                  |  |
| 13. FATHER'S NAME <u>Andrew Anderson</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Hanna Borgenson</u>  |  |   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>  |  |  |  | 16. SOCIAL SECURITY NO. <u>577-10-3205</u>  |  | 17. INFORMANT <u>Mr. Robert A. Anderson</u><br>Address <u>Box 12, 600 Barbara Road, Silver Spring, Md.</u>           |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>443X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension - arteriosclerosis</u><br>(c) <u>Heart Disease</u><br>DUE TO<br>(e), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |  |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 hours</u>   |  |   |  |  |  |                  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |  |  |   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |  |                  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |   |  |  |  |   |  |  |  |                  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>Dec 4</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Dec 4</u> , 19 <u>61</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.   |  |   |  |  |  |   |  |   |  |  |  | 22a. SIGNATURE<br><u>J. Marion Barkhead</u> M.D.  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED |  |
| 22c. PHYSICIAN'S NAME (Type) <u>J. Marion Barkhead</u>  |  | 22d. ADDRESS <u>9241 Col. Blvd. Silver Spring, Md.</u>  |  |  |  |   |  |   |  |  |  |   |  |  |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 23b. DATE THEREOF <u>12/7/61</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>CADDAR HILL CEMETERY</u>   |  | 23d. LOCATION (City, town or county) (State) <u>PRINCE GEORGE'S, MARYLAND</u> |  |   |  |  |  |   |  |  |  |                  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Harold E. Pumphrey, Inc.</u>   |  | 24a. ADDRESS<br><u>8434 GEORGIA AVENUE SILVER SPRING, MARYLAND</u>  |  | 25a. REC'D BY REGISTRAR<br><u>DEC 6 '61</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Carlton S. Hines</u>                         |  |   |  |  |  |   |  |  |  |                  |  |

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1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montg.</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Gaithersburg</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home</b>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Wilbur</b> Last <b>Arnold</b>   |  | 4. DATE OF DEATH Month <b>Dec.</b> Day <b>19</b> Year <b>1961</b>   |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Feb 16-1880</b>  |
| 9. AGE (In years lost birthday) <b>81</b> yrs.  |  | IF UNDER 1 YEAR Months <b>10</b> Days <b>5</b>  | IF UNDER 24 HRS. Hours <b></b> Min. <b></b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Baltimore. Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>   |  |
| 13. FATHER'S NAME <b>George Washington Arnold</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Laura Virginia Martzell</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |  | 16. SOCIAL SECURITY NO. <b></b>   |  |
| 17. INFORMANT <b>Records. Asbury Methodist Home</b>   |  | Address <b>Gaithersburg</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatosis, Generalized</b><br>DUE TO <b>177X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Prostate</b><br>DUE TO (c) <b></b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos</b><br><b>13 mos</b>                            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1960</b> to <b>Dec. 19</b> 1961, that (I) <del>(we)</del> last saw the deceased alive on <b>Dec 19</b> 1961, and that death occurred at <b>11:23</b> A. M. from the causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE <b>James W. Egan</b>   |  | 22b. DATE SIGNED <b>12-19-61</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>James W. Egan</b>   |  | 22d. ADDRESS <b>7720 Wisconsin Ave. - Bethesda, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE THEREOF <b>12-22-61</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove</b>  |  | 23d. LOCATION (City, town, or county) (State) <b>Sandy Mount. Md.</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner. Gaithersburg. Md.</b>  |  | 25a. REC'D BY REGISTRAR <b>DEC 22 '61</b>   |  |
|   |  | 25b. REGISTRAR'S SIGNATURE <b>Arthur J. Kline</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14047

14015

|  |                           |  |                                       |
|--|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b><br>c. LENGTH OF STAY IN b. <b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8000 PINEY BRANCH ROAD</b>   |                           | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>24 TAKOMA PARK</b><br>d. STREET ADDRESS <b>18000 PINEY BRANCH ROAD</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                       |
| 3. NAME OF DECEASED (Type or print) <b>DAISY E. BARNHART</b>   |                           | 4. DATE OF DEATH <b>DEC. 25, 1961</b>  |                                       |
| 5. SEX <b>F</b>  | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>JAN. 13, 1890</b> |
| 9. AGE (In years last birthday) <b>71</b> yrs.   |                           | 10. IF UNDER 1 YEAR: Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min.   |                                       |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>   |                           | 11b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>  |                                       |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                           | 13. BIRTHPLACE (County & State, or foreign country) <b>PENNA.</b>  |                                       |
| 13. FATHER'S NAME <b>DAVID FRYE</b>  |                           | 14. MOTHER'S MAIDEN NAME <b>IDA NICHOLSON</b>  |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |                           | 16. SOCIAL SECURITY NO. <b>STANLEY R. BARNHART 8000 PINEY BRANCH RD.</b>   |                                       |
| 17. INFORMANT <b>STANLEY R. BARNHART</b>   |                           | Address <b>TAKOMA PARK, MD.</b>  |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia, Renal Failure</b><br><b>592X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Chronic Glomerulonephritis</b><br>(a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatic Heart Disease</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b><br><b>10 yr</b> |                           |  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that (I) (the hospital) attended the deceased from <b>June 1961</b> to <b>23-Dec., 1961</b> , that (I) (we) last saw the deceased alive on <b>24 Dec. 1961</b> , and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above.   |                           |  |                                       |
| 22a. SIGNATURE <b>H. B. QUEEN M.D.</b>   |                           | 22b. DATE SIGNED <b>25-Dec-1961</b>  |                                       |
| 22c. PHYSICIAN'S NAME (Type) <b>H. B. QUEEN</b>  |                           | 22d. ADDRESS <b>712 WILLOW AVE. TAKOMA PARK, MD.</b>   |                                       |
| 23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>  |                           | 23b. DATE THEREOF <b>DEC. 1961</b>   |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY <b>LIGNIER VALLEY CEM.</b>  |                           | 23d. LOCATION (City, town or county) (State) <b>LIGNIER PENNA.</b>   |                                       |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>254 MARSH ST. N.W. D.C.</b>  |                           | 25a. REC'D BY REGISTRAR <b>DEC 27 '61</b>  |                                       |
| 25b. REGISTRAR'S SIGNATURE <b>Clara S. Harris</b>  |                           |  |                                       |



1907

January

Thurs Jan 3

Good Day, Thursday

Friday

Sat Jan 5

Sunday

Good Day, Sunday

Monday

1907

January

Good Day, Thursday

Friday

Sat Jan 5

Sunday

Good Day, Sunday

1907

January

Good Day, Thursday

Friday

Sat Jan 5

Sunday

Good Day, Sunday

Monday

Good Day, Monday

Tuesday

Good Day, Tuesday

Wednesday

Good Day, Wednesday

Thursday

Good Day, Thursday

Friday

Good Day, Friday

Saturday

Good Day, Saturday

Sunday

Good Day, Sunday



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14048

## CERTIFICATE OF DEATH

14016

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY in <u>MARYLAND</u> <u>3 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>           |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>New Jersey</u> b. COUNTY <u>Mercer</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Princeton</u><br>d. STREET ADDRESS <u>46 Chestnut Street</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>f. DATE OF DEATH <u>Dec - 10 1961</u><br>g. AGE (in years last birthday) <u>21</u> yrs. IF UNDER 1 YEAR: Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>ANNA L. BARRON</u><br><b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u><br><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>         |  | <b>8. DATE OF BIRTH</b> <u>2/19/80</u><br><b>9. AGE</b> (in years last birthday) <u>21</u> yrs. IF UNDER 1 YEAR: Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Librarian (ret.)</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Princeton, N.J.</u><br><b>11. BIRTHPLACE</b> (County & State or foreign country) <u>Nova Scotia</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Canadian</u> |  | <b>13. FATHER'S NAME</b> <u>Andrew Barron</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Mary</u>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u><br><b>16. SOCIAL SECURITY NO.</b> <u>no</u><br><b>17. INFORMANT</b> <u>Edw. P. Carr / Bethesda, Md.</u>   |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Infarction of Myocardium</u><br>(b) <u>Coronary atherosclerosis</u><br>(c) <u>Generalized arteriosclerosis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <u>10</u> m. <u>19</u> p.m.  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Spring</u> <u>1960</u> to <u>Dec 10</u> , 19 <u>61</u> , that (I) <u>did</u> last saw the deceased alive on <u>Dec 10</u> , 19 <u>61</u> , and that death occurred at <u>10</u> p.m. from the causes and on the date stated above.                       |  |   |  |
| <b>22a. SIGNATURE</b> <u>James W. Egan</u><br><b>22c. PHYSICIAN'S NAME</b> (Type) <u>James W. Egan</u>   |  | <b>22b. DATE SIGNED</b> <u>12-10-61</u><br><b>22d. ADDRESS</b> <u>7720 Wisconsin Avenue, Bethesda Md.</u>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial-Transit 12/11/61</u>  |  | <b>23b. DATE THEREOF</b> <u>12/11/61</u>  |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Paul Cemetery</u>   |  | <b>23d. LOCATION</b> (City, town or county) (State) <u>Princeton, New Jersey</u>  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u>  |  | <b>25a. REC'D BY REGISTRAR</b> <u>DEC 13 '61</u><br><b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Kline</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11/10/85

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

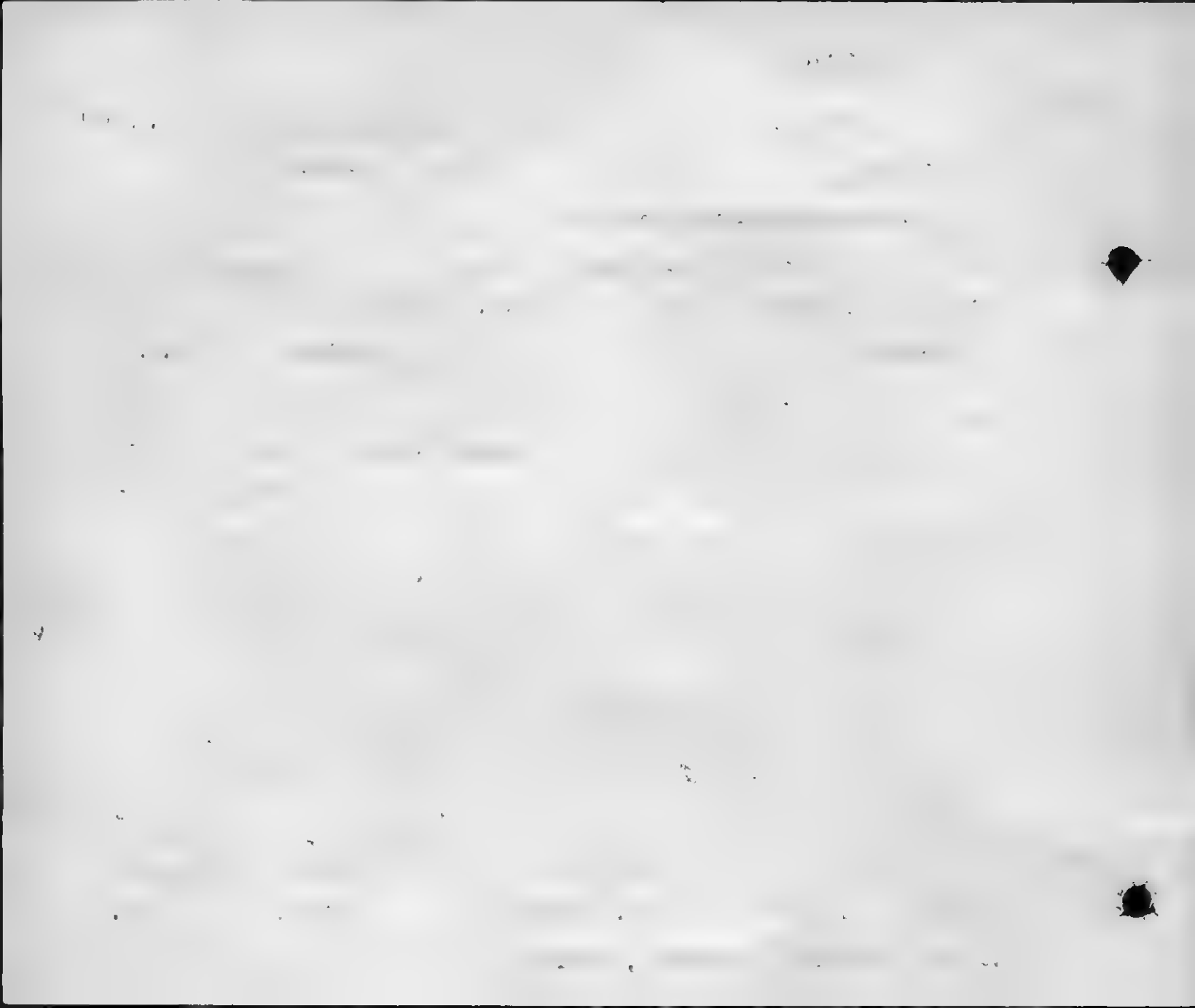
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

14049

14017

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br><b>a. COUNTY</b> <u>Montgomery</u> <b>MARYLAND</b><br><b>b. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br><b>c. LENGTH OF STAY IN</b> <u>1b</u><br><b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address) <u>Resmore Sanitarium &amp; Hospital</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br><b>a. STATE</b> <u>Maryland</u> <b>b. COUNTY</b> <u>St. Mary's</u><br><b>c. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <u>Rural Scotland</u><br><b>d. STREET ADDRESS</b> <u>138</u>  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Harry Alexander Beal</u><br><b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u><br><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Feb. 1872</u><br><b>9. AGE</b> (In years) <u>89</u> <b>10. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u><br><b>11. BIRTHPLACE</b> (Country & State, or foreign country) <u>Maryland</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u> |  | <b>4. DATE OF DEATH</b> <u>December 10, 1961</u><br><b>9. AGE</b> (In years) <u>89</u> <b>10. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u><br><b>11. BIRTHPLACE</b> (Country & State, or foreign country) <u>Maryland</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>   |  |
| <b>13. FATHER'S NAME</b> <u>?</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>?</u><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>?</u> <b>16. SOCIAL SECURITY NO.</b> <u>?</u><br><b>17. INFORMANT</b> <u>Hospital Records Same as # 2 above</u>  |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br><b>PART I. DEATH WAS CAUSED BY:</b><br>IMMEDIATE CAUSE (a) <u>CARDIO VASCULAR COLLAPSE</u><br>DUE TO (b) <u>CORONARY ARTERY DISEASE</u><br>DUE TO (c) <u>ARTERIO SCLEROSIS GENL.</u><br><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b><br><u>URINARY TRACT INFECTION WITH UREMIA</u>  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u><br>Hour a.m. <u>19</u> p.m. <u>19</u><br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>17</u><br><b>20f. (City or town)</b> <u>17</u> (County) <u>17</u> (State) <u>17</u>   |  | <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br><b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Oct. 17, 1961</u> to <u>12/10/61</u> , that (I) (we) last saw the deceased alive on <u>12/9/61</u> , and that death occurred at <u>5:40</u> M., from the causes and on the date stated above.<br><b>22a. SIGNATURE</b> <u>Charles J. Savarose, Jr.</u> M.D. <b>22b. DATE</b> <u>12/11/61</u><br><b>22c. PHYSICIAN'S NAME (Type)</b> <u>CHARLES J. SAVAROSE, JR.</u> <b>22d. ADDRESS</b> <u>4896 BATTERY LAKE</u><br><u>BETHESDA, MD.</u> |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u><br><b>23b. DATE THEREOF</b> <u>12/12/61</u><br><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Michaels</u><br><b>23d. LOCATION (City, town or county)</b> <u>Ridge, Md.</u>   |  | <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. Clarke Mattingley</u> <b>25. REC'D BY REGISTRAR</b> <u>DEC 15 '61</u><br><b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles J. Savarose</u>   |  |

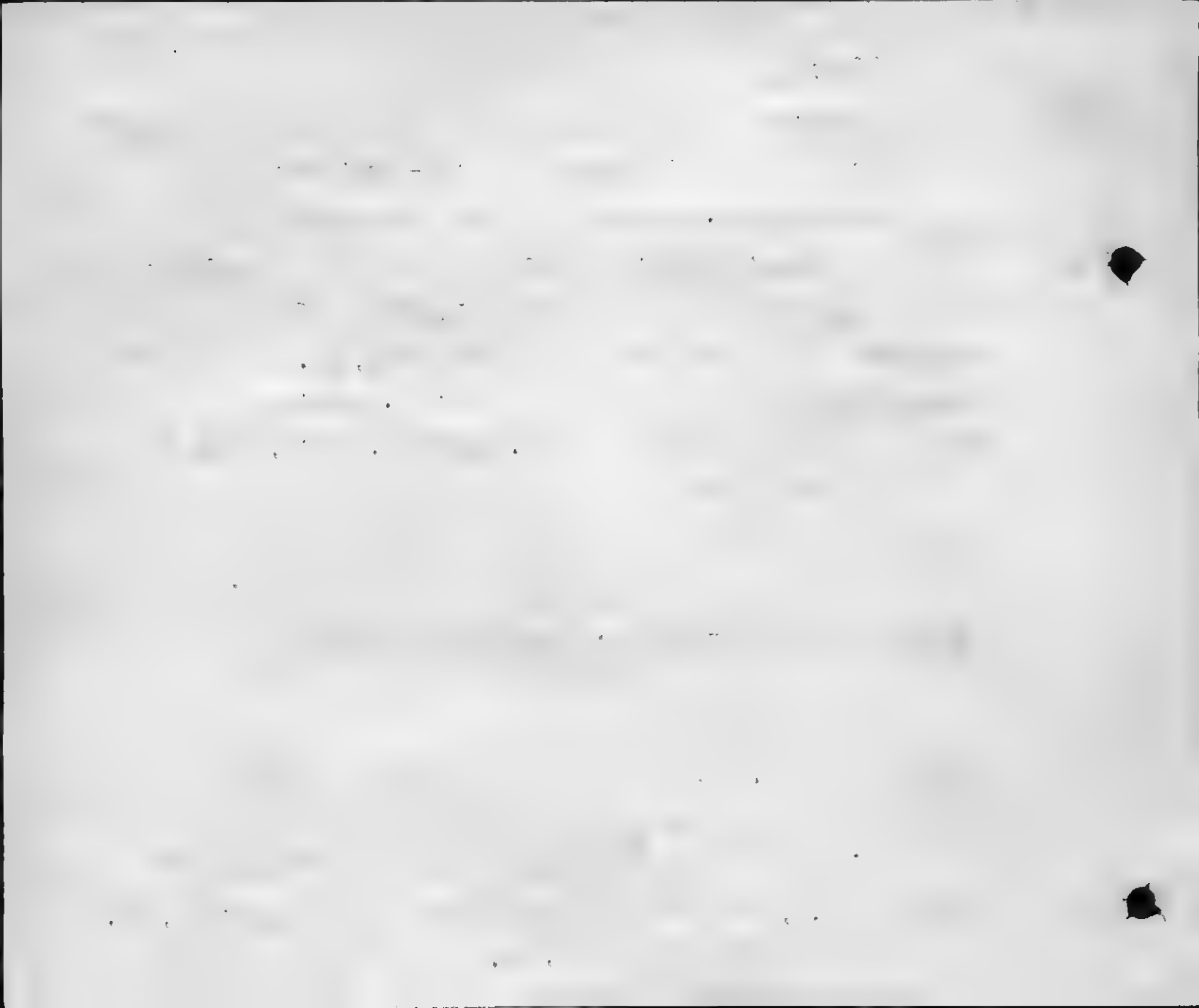


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| <div> <div> <div>1</div> <div>14050</div> </div> <div> <div>M</div> <div>1</div> </div> </div> <div> <div> <div>14018</div> <div>14018</div> </div> <div> <div>14018</div> <div>14018</div> </div> </div>  |  |  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b><br>c. LENGTH OF STAY IN 1b <b>3 weeks</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery Gen. Hospital</b>   |  |  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>e. STATE <b>Maryland</b> <b>Montgomery</b><br>f. COUNTY <b>Montgomery</b><br>g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Lewisdale</b><br>h. STREET ADDRESS <b>RFD Clarksburg</b><br>i. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><b>Bessie Lewis Beall</b><br>First Middle Last<br><b>Female</b> <b>White</b><br><b>Housewife</b> <b>Own home</b><br><b>Filmore Lewis</b>   |  |  |  |  |  | <b>4. DATE OF DEATH</b> <b>December 30 1961</b><br>Last Month Day Year<br><b>5. SEX</b> <b>Female</b> <b>White</b><br><b>6. COLOR OR RACE</b> <b>White</b><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/><br><b>8. DATE OF BIRTH</b> <b>July 21, 1893</b><br>9. AGE (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.<br><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own home</b><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Lewisdale, Md.</b><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b><br><b>13. FATHER'S NAME</b> <b>Filmore Lewis</b><br><b>14. MOTHER'S MAIDEN NAME</b> <b>Olive M. Watkins</b><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)<br><b>16. SOCIAL SECURITY NO.</b> <b>None</b><br><b>17. INFORMANT</b> <b>Mr. Leslie G. Beall, Item 2</b> Address |  |  |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br>(b) <b>Generalized Arteriosclerosis with Coronary Sclerosis</b><br>(c) <b>Hypertensive Arteriosclerotic Cardio-vascular Disease with Congestive Heart Failure.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus - Severe. Congestive Heart Failure</b><br><b>Hypertensive Arteriosclerotic Cardio-vascular Disease</b><br>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19<br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br><b>21. I certify that (I) (this hospital) attended the deceased from Jan. 1965, to Dec. 30, 1961, that (I) saw the deceased alive on Dec. 30, 1961, and that death occurred at 2:00 P.M. from the causes and on the date stated above.</b><br><b>22a. SIGNATURE</b> <b>M. McKendree Boyer</b> M.D. <b>12/31/61</b><br><b>22b. DATE</b><br><b>22c. PHYSICIAN'S NAME (Type)</b> <b>M. McKendree Boyer, M. D.</b><br><b>22d. ADDRESS</b> <b>9830 Main Street, Damascus, Maryland</b><br><b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b><br><b>23b. DATE THEREOF</b> <b>Jan. 2, 1962</b><br><b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Bethesda Methodist</b><br><b>23d. LOCATION (City, town or county) (State)</b> <b>Browningsville, Md.</b><br><b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Olin L. McLean</b> ADDRESS <b>Damascus, Md.</b><br><b>25a. REC'D BY REGISTRAR</b> <b>JAN 4 1962</b><br><b>25b. REGISTRAR'S SIGNATURE</b> <b>William S. Thomas</b> |  |  |  |  |  |   |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

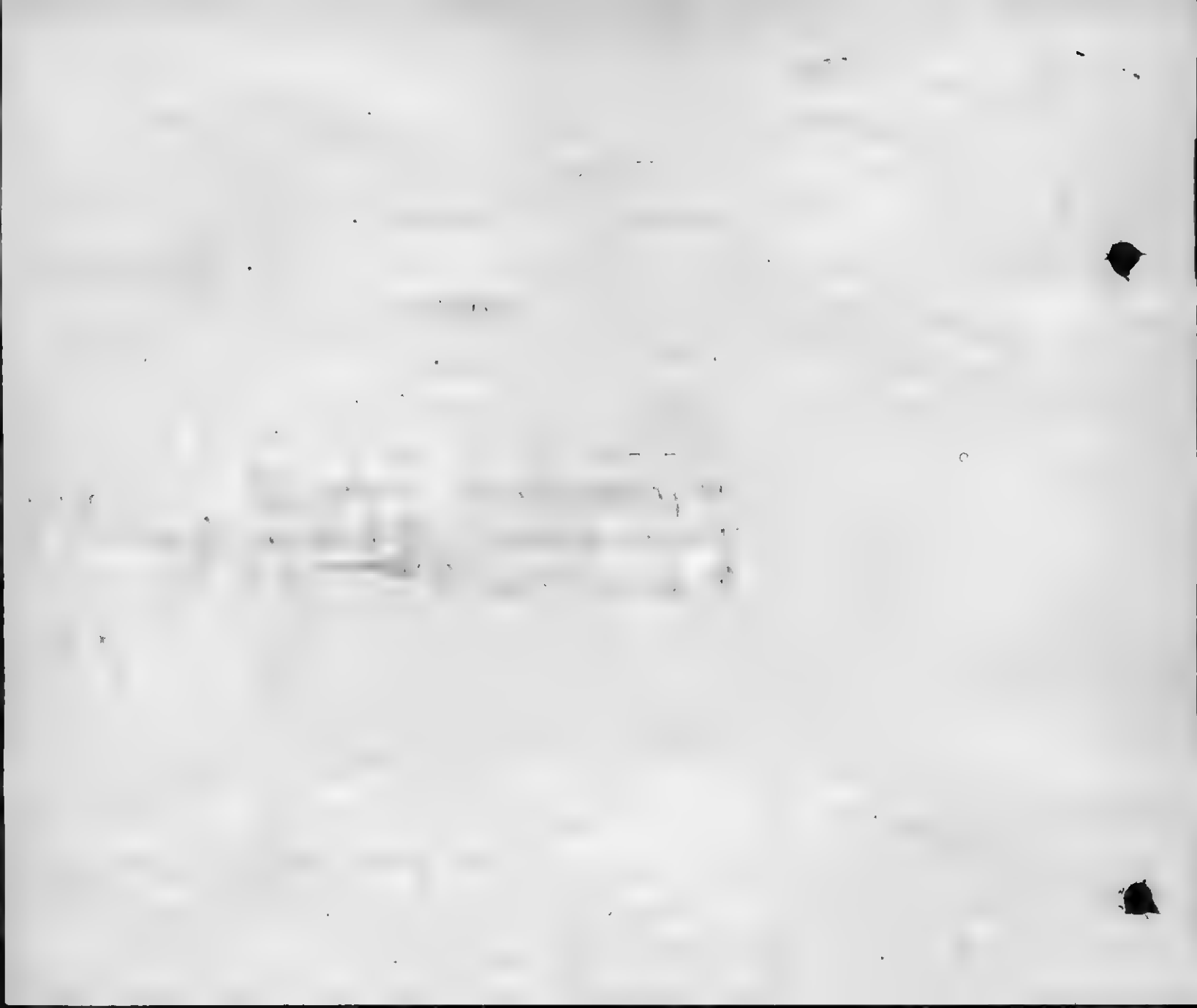
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14051

14019

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>  |  |
| c. LENGTH OF STAY IN 1b <u>11 days</u>  |  | d. STREET ADDRESS <u>4605 West Va. Ave</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN Hospital</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>JOHN</u> Middle <u>M</u> Last <u>BECK</u>   |  | 4. DATE OF DEATH<br>Month <u>DEC</u> Day <u>31</u> Year <u>1961</u>   |  |
| 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |
| 8. DATE OF BIRTH <u>10/12/1901</u>  |  | 9. AGE (In years last birthday) <u>60</u> yrs. If UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> If UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painting Contractor</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>   |  |
| 11. PLACE (County & State, or foreign country) <u>U.S.A</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>   |  |
| 13. FATHER'S NAME <u>George W. Beck</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Icey Lindsay Lillian S. Beck</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  | 16. SOCIAL SECURITY NO. <u>325-14-2167</u>  |  |
| 17. INFORMANT <u>Wife Same as above</u>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>(a) IMMEDIATE CAUSE (b) DUE TO (c) DUE TO<br><u>Myocardial infarct</u><br><u>Thrombosis, Left anterior descending coronary artery</u><br><u>Arteriosclerosis</u> |  |
| 19. INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>   |  | 20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.) <u>  </u>   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>  |  | 20f. (City or town, County, State) <u>  </u>  |  |
| 21. I certify that (I) (the hospital) attended the deceased from <u>JUNE 22, 1961</u> , to <u>DEC. 31, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec. 30, 1961</u> , and that death occurred at <u>9:35 A.M.</u> from the causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE <u>Robert G. Angle</u>   |  | 22b. DATE SIGNED <u>12/31/61</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert Angle</u>  |  | 22d. ADDRESS <u>5009 DelRay Avenue, Bethesda, Md.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE THEREOF <u>1/3/62</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>   |  | 23d. LOCATION (City, town or county) <u>Rockville, Maryland</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>  |  | 25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>  </u>  |  |
| 25c. ADDRESS <u>Bethesda, Md.</u>   |  | 25d. DATE <u>JAN 3 '62</u>  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14052

14020

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b>  |  | b. COUNTY<br><b>Montgomery</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural- Clarksburg</b>  |  | c. LENGTH OF STAY IN 1b<br><b>years</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural- Clarksburg</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>RFD # 1</b>  |  | d. STREET ADDRESS<br><b>RFD # 1</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Della F. Bennett</b>   |  | 4. DATE OF DEATH<br><b>Dec. 12 1961</b>   |  | 5. SEX<br><b>Female</b>   |  |
| 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Aug. 15, 1882</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |  | 9. AGE (In years last birthday)<br><b>79</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Montgomery Co., Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 13. FATHER'S NAME<br><b>W.F.L. Clagett</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Heneriетter Watkins</b>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>                                       |  | 16. SOCIAL SECURITY NO<br><b>-----</b>  |  |
| 17. INFORMANT<br><b>Dosey L. Bennett,</b>   |  | Address<br><b>Item 2</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive Heart Disease</b><br>DUE TO <b>Auricular Fibrillation</b><br>(b) <b>Generalized Arteriosclerosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Acute Gastro-enteritis (Viral?)</b>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>15 yrs.</b><br><b>14 yrs.</b><br><b>15 yrs. ?</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>Not an accident</b>  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  | 20c. TIME OF INJURY<br>Month, Day, Year<br><b>19</b>  |  |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br>(County)<br>(State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1941</b> to <b>December 12, 1961</b> (we) last saw the deceased alive on <b>December 12, 1961</b> that death occurred at <b>2 P.M.</b> from the causes and on the date stated above. |  |   |  |   |  |
| 22a. SIGNATURE<br><i>M. McKendree Boyer</i>   |  | 22b. DATE SIGNED<br><b>Dec. 13, 1961</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>M. McKendree Boyer, M.D.</b>   |  |
| 22d. ADDRESS<br><b>9830 Main Street, Damascus, Md.</b>  |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>Dec. 15, 1961</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Clarksburg Meth.</b>   |  | 23d. LOCATION (City, town or county)<br><b>Clarksburg, Md.</b>  |  | 23e. REC'D BY REGISTRAR<br><b>DEC 18 '61</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><i>Olin L. Moksouth</i>   |  | 24b. ADDRESS<br><b>Damascus, Md.</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thos. E. Krasner</i>   |  |

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MEDICAL CERTIFICATION  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

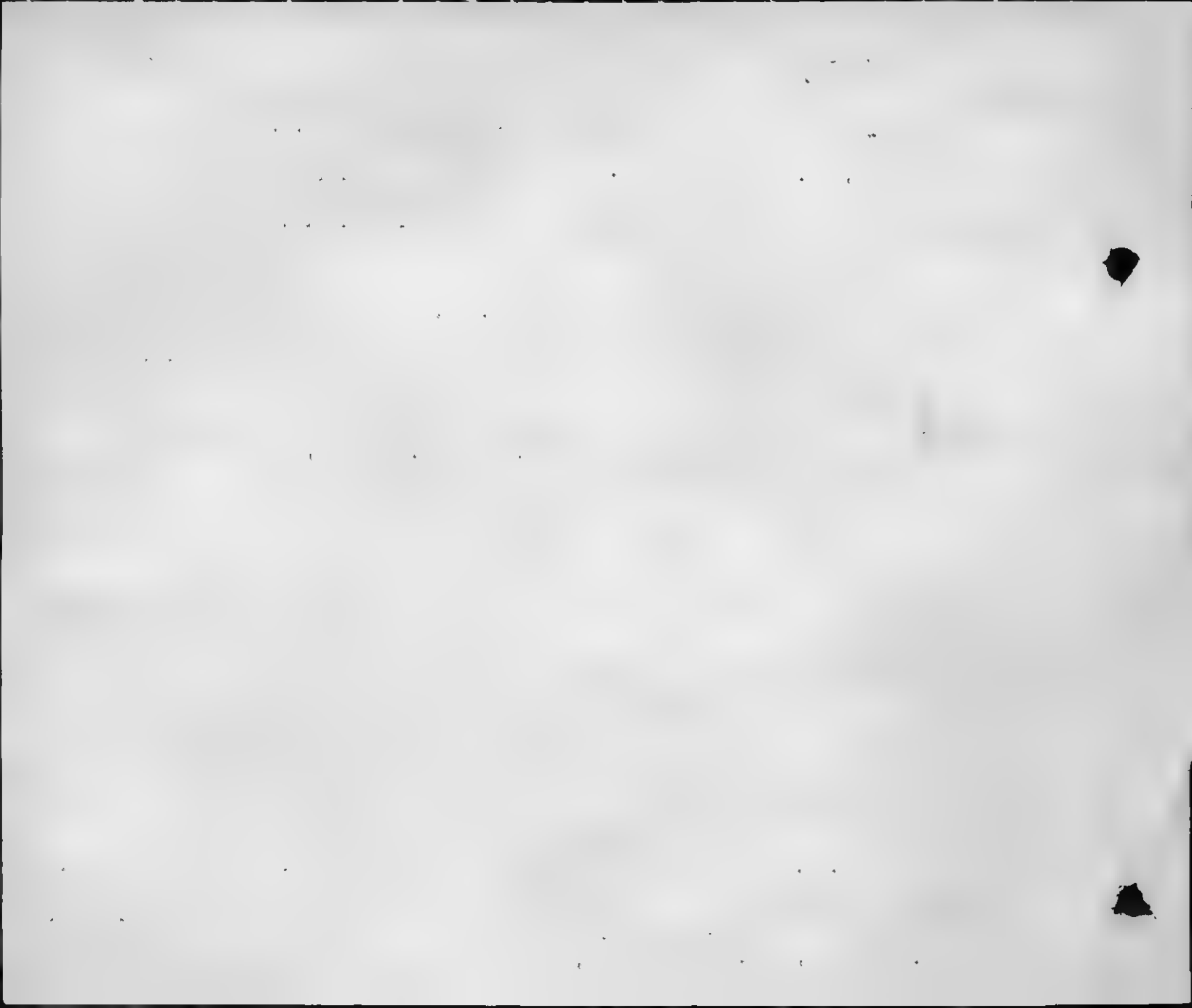


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**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |
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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |
| 14053  |  | 14021   |  |
| CERTIFICATE OF DEATH   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Montgomery</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><u>MARYLAND</u><br>b. COUNTY<br><u>Washington D.C.</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington D.C.</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring, Md.</u>  |  | c. LENGTH OF STAY IN 1b<br><u>4mo.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Althea Woodland, 1000 Daleview Drive</u>  |  | d. STREET ADDRESS<br><u>4607 Conn. Ave. N.W.</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Elsie Havener Bennett</u>  |  | 4. DATE OF DEATH<br><u>December 17, 1961</u>  |  |
| 5. SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>white</u>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u>  |  | 8. DATE OF BIRTH<br><u>Sept. 11, 1878</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Clerk General Accounting office</u>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Virginia</u>  |  |
| 13. FATHER'S NAME<br><u>Wesley Francis Havener</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Martha Ann Cleary</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>None</u>   |  | 17. INFORMANT<br><u>Mrs. Elsie H. Bennett,</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><u>3-1-X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br><u>hypertension</u><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.<br><u>Psychotic state</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1-2 days</u><br><u>js</u>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/11/1959</u> to <u>12/19/1961</u> that (I) (we) last saw the deceased alive on <u>12/12/1961</u> , and that death occurred at <u>12/19/1961</u> M, from the causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE<br><u>C. H. Wolohon</u>   |  | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>C. H. Wolohon</u>   |  | 22d. ADDRESS<br><u>800 Pershing Dr. Silver Spring, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>12/19/61</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rock Creek Cemetery</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Rock Creek Church Rd. Wash. DC</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Warner E. Pumphrey, Inc. Silver Spring, Maryland</u>  |  | 25a. REC'D BY REGISTRAR<br><u>DEC 22 '61</u>  |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert S. Pumphrey</u>   |  |





HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The attending physician and the funeral director must be filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14054

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14022

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN b. <u>41 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>2412 Dennis Avenue</u> |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><u>George Oliver Berger</u>   |  | <b>4. DATE OF DEATH</b><br><u>December 18, 1961</u>   |  | <b>5. SEX</b> <u>Male</u>   |  |
| <b>6. COLOR OR RACE</b> <u>White</u>  |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b> <u>2 February 1880</u>  |  |
| <b>9. AGE</b> (In years if UNDER 1 YEAR, F UNDER 24 HRS., last birthday) <u>81 yrs.</u>   |  | <b>10. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>   |  | <b>11. BIRTHPLACE</b> (County & State or foreign country) <u>Pennsylvania</u>                   |  |
| <b>12. FATHER'S NAME</b> <u>Elias Berger</u>  |  | <b>13. MOTHER'S MAIDEN NAME</b> <u>Emma Hunsicker</u>   |  | <b>14. INFORMANT</b> <u>The Medical Record</u>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>  |  | <b>16. SOCIAL SECURITY NO.</b> <u>None</u>  |  | <b>17. ADDRESS</b> <u>The Clinical Center, Bethesda 14, Maryland</u>                            |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br><u>154X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Lymphoma</u><br>(c) <u>Post-op Carcinoma of rectum</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Interval between ONSET AND DEATH</u> |  |   |  |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)                   |  |
| <b>20f. (City or town)</b> <u>Washington D.C.</u>   |  | <b>20g. (County)</b> <u>Washington D.C.</u>   |  | <b>20h. (State)</b> <u>Washington D.C.</u>  |  |
| <b>21. I certify that</b> (X (this hospital) attended the deceased from <u>November 7, 1961</u> to <u>December 18, 1961</u> , that (X) (we) last saw the deceased alive on <u>December 18, 1961</u> , and that death occurred <u>2:10 PM</u> from the causes and on the date stated above.  |  |   |  |   |  |
| <b>22a. SIGNATURE</b> <u>Marvin Pomerantz</u>   |  | <b>22b. PHYSICIAN'S NAME</b> (Type) <u>Marvin Pomerantz M.D.</u>  |  | <b>22c. ADDRESS</b> <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u> |  |
| <b>22d. ATTENDING PHYS.</b> <input type="checkbox"/> <b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>22f. STAFF PHYS.</b> <input checked="" type="checkbox"/> <u>12-18-61</u>   |  | <b>22g. DATE SIGNED</b> <u>12-18-61</u>   |  | <b>22h. SIGNATURE</b> <u>Raymond E. Pumphrey</u>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>  |  | <b>23b. DATE THEREOF</b> <u>12/21/61</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rock Creek Cemetery</u>                            |  |
| <b>23d. LOCATION</b> (City, town or county) <u>Washington D.C.</u>  |  | <b>23e. (State)</b> <u>Washington D.C.</u>  |  | <b>23f. REC'D BY REGISTRAR</b> <u>DEC 22 '61</u>  |  |
| <b>23g. REGISTRAR'S SIGNATURE</b> <u>Raymond E. Pumphrey</u>  |  | <b>23h. ADDRESS</b> <u>8434 Georgia Avenue Silver Spring, Maryland</u>  |  | <b>23i. REGISTRAR'S SIGNATURE</b> <u>Raymond E. Pumphrey</u>                                    |  |

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| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Montgomery</i>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before adm. ssion)<br>a. STATE<br><i>Ind</i><br>b. COUNTY<br><i>Montg</i>   |  |
| b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town)<br><i>Bethesda</i>   |  | c. LENGTH OF STAY IN 1b<br><i>120A</i>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><i>Suburban Hospital</i>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><i>James Henry Bettis</i>  |  | 4. DATE OF DEATH<br>Month <i>Jan</i> Day <i>29</i> Year <i>1961</i>   |  |
| 5. SEX<br><i>Male</i>  |  | 6. COLOR OR RACE<br><i>White</i>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><i>?</i>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>laborer</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>retired</i>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Va</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.C.</i>   |  |
| 13. FATHER'S NAME<br><i>James W. Bettis</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>Susan Groves</i>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><i>No</i>  |  | 16. SOCIAL SECURITY NO.<br><i>213-142239</i>  |  |
| 17. INFORMANT<br><i>Robert J. Bettis</i>   |  | 18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e)<br><i>420.1</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e)<br><i>Coronary occlusion</i> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><i>19</i>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| EXAMINER'S SIGNATURE<br><i>Frank J. Blaszczak</i>  |  | DATE SIGNED<br><i>12-29-61</i>  |  |
| EXAMINER'S NAME (Type)<br><i>FRANK J. BLASZCZAK</i>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 22b. DATE THEREOF<br><i>1/4/62</i>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><i>Parklawn</i>  |  | 22d. LOCATION (City, town, or country) (State)<br><i>Rockville, Ind.</i>  |  |
| 23. FUNERAL DIRECTOR<br><i>Lynn Wheeler</i>  |  | 24a. REC'D BY REGISTRAR<br><i>JAN 5 '62</i>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Hume</i>  |  |   |  |



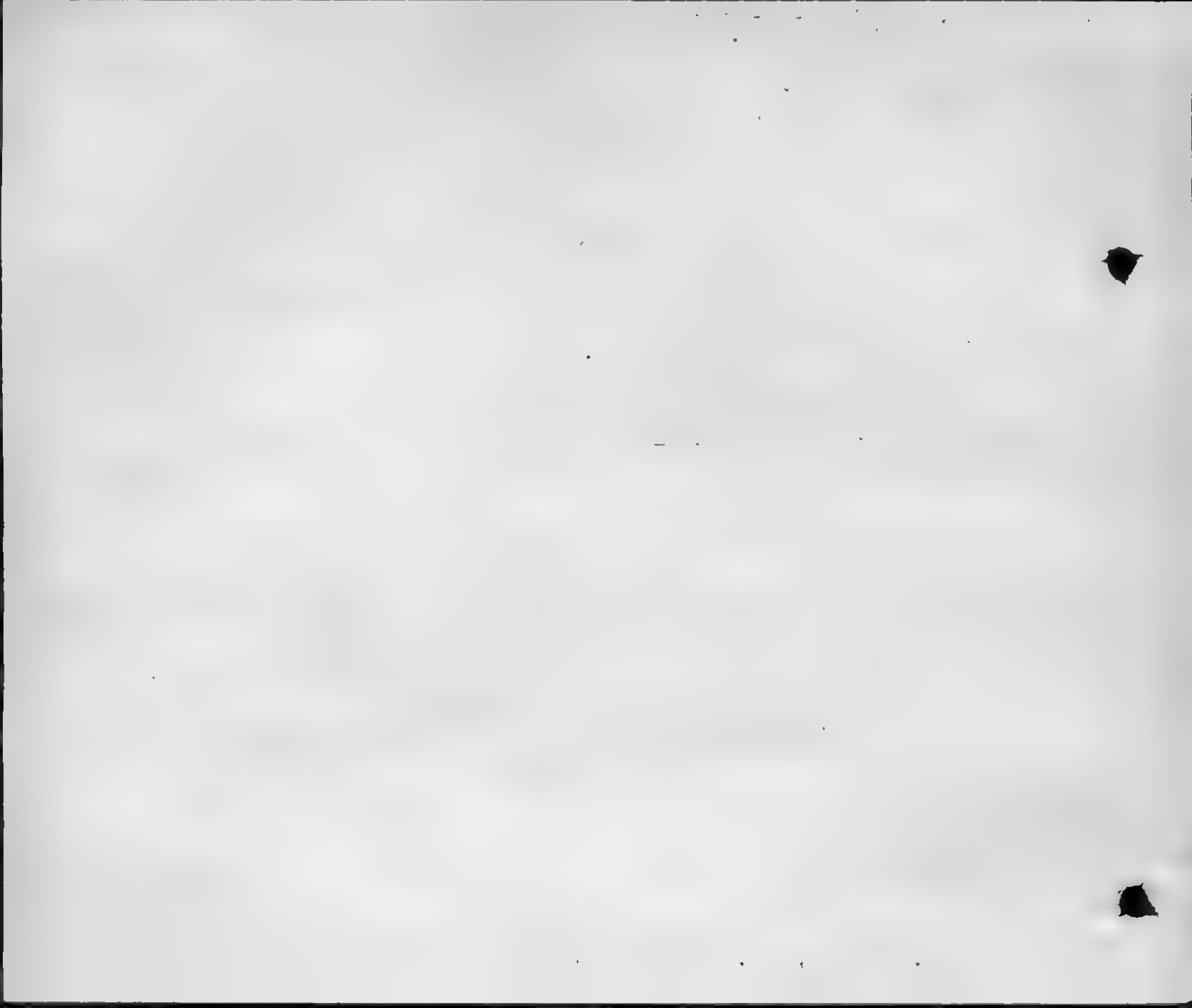
(M)

7-1

any delay is necessary, the funeral director, Page 3, may be retained for your files. Page 2 with the State Board of Health, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |  |  |   |  |  |  |
| 14056 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |  |  |
| 14024  |  |  |  |  |  |  |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Montg</u>                       |  |  |  |   |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>   |  |  |  | c. LENGTH OF STAY IN 1b <u>50 A</u>  |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montg Gen Hosp</u>   |  |  |  | d. STREET ADDRESS <u>Colesville-Beltville Rd</u>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>John Bixioner</u>   |  |  |  | 4. DATE OF DEATH <u>12-18-1961</u>   |  |  |  | 5. SEX <u>male</u>  |  |  |  |
| 6. COLOR OR RACE <u>white</u>  |  |  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 8. DATE OF BIRTH <u>12-19-24</u>  |  |  |  |
| 9. AGE (In years last birthday) <u>36</u> yrs.   |  |  |  | 10. AGE (In years last birthday) <u>36</u> yrs.  |  |  |  | 11. AGE (In years last birthday) <u>36</u> yrs.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dep Sheriff</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Montgomery Co.</u>  |  |  |  | 11. BIRTHPLACE (State or foreign country) <u>Pas</u>  |  |  |  |
| 13. FATHER'S NAME <u>Peter Bixioner</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Alice Christos</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>   |  |  |  | 16. SOCIAL SECURITY NO. <u>149-12-5240</u>   |  |  |  | 17. INFORMANT <u>Joe P. Bixione</u> Address <u>13201 Kara Lane Silver Spring</u>                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br>929.8 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>drowning</u><br>DUE TO<br>(c)  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned while retrieving a duck which he shot</u>        |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>?</u> p.m. <u>12-18-1961</u>   |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pond</u>                    |  |  |  |
| 20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>md</u>   |  |  |  |  |  |  |  |   |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Bloch</u>   |  |  |  | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  | DATE SIGNED <u>12-18-61</u>   |  |  |  |
| EXAMINER'S NAME (Type) <u>FRANK J. BLOCH</u>   |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  | Address (Street, city, town, or county) <u>12-18-61</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |  |  | 22b. DATE THEREOF <u>12/21/61</u>  |  |  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington Virginia</u>              |  |  |  |
| 22d. LOCATION (City, town, or country) <u>Virginia</u>   |  |  |  |  |  |  |  |   |  |  |  |
| 23. FUNERAL DIRECTOR <u>Raymond A Ziska</u> ADDRESS <u>8434 Georgia Avenue</u>   |  |  |  | 24a. REC'D BY REGISTRAR <u>DEC 22 '61</u>  |  |  |  | 24b. REGISTRAR'S SIGNATURE <u>W. E. Pumphrey</u>  |  |  |  |
| Warner E. Pumphrey, Inc. Silver Spring, Maryland   |  |  |  |  |  |  |  |   |  |  |  |





1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14057

Item 25b, Film G303 12/19/61 iwk

14025

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <u>Louisiana</u> b. COUNTY _____ |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda (Rural)</u>  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Bossier City</u>                            |  |
| c. LENGTH OF STAY IN 1b<br><u>17 days</u>  |  | d. STREET ADDRESS<br><u>2273-A N. Plantation Drive</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>U. S. Naval Hospital</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>David</u> Middle <u>Leslie</u> Last <u>Blackwell</u>  |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>12</u> Year <u>1961</u>   |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>Caucasian</u>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH<br><u>November 11, 1961</u>   |  | 9. AGE (in years last birthday) Months <u>1</u> Days <u>5</u> Hours <u>5</u> M.in. _____   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>_____   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>_____   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Louisiana</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 13. FATHER'S NAME<br><u>Jerry D. Blackwell</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Sybill Bizzell</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO. _____  |  |
| 17. INFORMANT<br><u>FATHER: Jerry D. Blackwell, same as #2</u>   |  | Address _____  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u><br><u>754.5</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>(Transposition of A.S.D. &amp; V.S.D.)</u><br>(c) <u>754.5</u> DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br>_____ |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>_____  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   |  |  |  |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/>  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>_____  |  |  |  |
| 20f. (City or town) _____ (County) _____ (State) _____   |  |  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Nov. 26</u> , 19 <u>61</u> , to <u>Dec. 12</u> , 19 <u>61</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Dec. 12</u> , 19 <u>61</u> , and that death occurred at <u>2:00 PM</u> from the causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE <u>M. C. O'Bannon</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>December 12, 1961</u>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>M. C. O'BANNON LT MC USN</u> <u>U. S. Naval Hospital, Bethesda, Md.</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>12/16/61</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>New Smyrna Cemetery</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Smyrna, Ga.</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Tyson Wheeler</u>   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 15 '61</u>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>A. J. S. Evans</u>  |  | 25c. REGISTRAR'S SIGNATURE<br><u>A. J. S. Evans</u>  |  |



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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and duly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14058

## CERTIFICATE OF DEATH

Items 4, 18 & 22 Film G302 12/8/61 iwk

14026

### 1. PLACE OF DEATH

#### a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN b

27 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

The Clinical Center, Bethesda 14, Md.

### 3. NAME OF DECEASED (Type or print)

First

Ruby

Middle

Lee

Last

Bodmer

### 5. SEX

Female

### 6. COLOR OR RACE

White

### 7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

### 8. DATE OF BIRTH

September 24, 1912/49

### 9. AGE (In years 'IF UNDER 1 YEAR last birthday)

Years Months Days Hours Min.

1961

### 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

### 10b. KIND OF BUSINESS OR INDUSTRY

Telephone Company

### 11. BIRTHPLACE (Country & State, or foreign country)

Virginia

### 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

### 13. FATHER'S NAME

Robert G. Cooper

### 14. MOTHER'S MAIDEN NAME

Ollie Atwell

### 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

No

### 16. SOCIAL SECURITY NO

223-09-1520

### 17. INFORMANT

The Medical Record

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

#### PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Renal failure, probably due to acute tubular necrosis 8 days

#### (b)

Massive hemorrhage, retroperitoneal, peritoneal, peri-renal. 9 days

#### (c)

Triangle Abscess, right femoral triangle, thrombosis R. iliac vein 14 days

### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

### 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

### 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

### 20c. TIME OF INJURY

Hour a.m. p.m.

### 20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

### 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

### 20f. (City or town)

### (County)

### (State)

21. I certify that (X) (this hospital) attended the deceased from Nov. 8 1961 to Dec. 5 1961 that (we) last saw the deceased alive on Dec. 5 1961, and that death occurred at 4:30 PM from the causes and on the date stated above.

### 22a. SIGNATURE

Joseph H. Pilch

M.D.

### ATTENDING PHYS.

### MED. DIRECTOR

### STAFF PHYS.

### 22c. PHYSICIAN'S NAME (Type)

Joseph

Joseph H. Pilch, M.D.

### 22d. ADDRESS

The Clinical Center, National

Institutes of Health, Bethesda 14, Md.

### 23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial Dec. 8, 1961

### 23b. DATE THEREOF

### 23c. NAME OF CEMETERY OR CREMATORY

Leesburg

### 23d. LOCATION (City, town or county)

Leesburg

### (State)

VA

### 24. FUNERAL DIRECTOR'S SIGNATURE

J. J. Muse

### ADDRESS

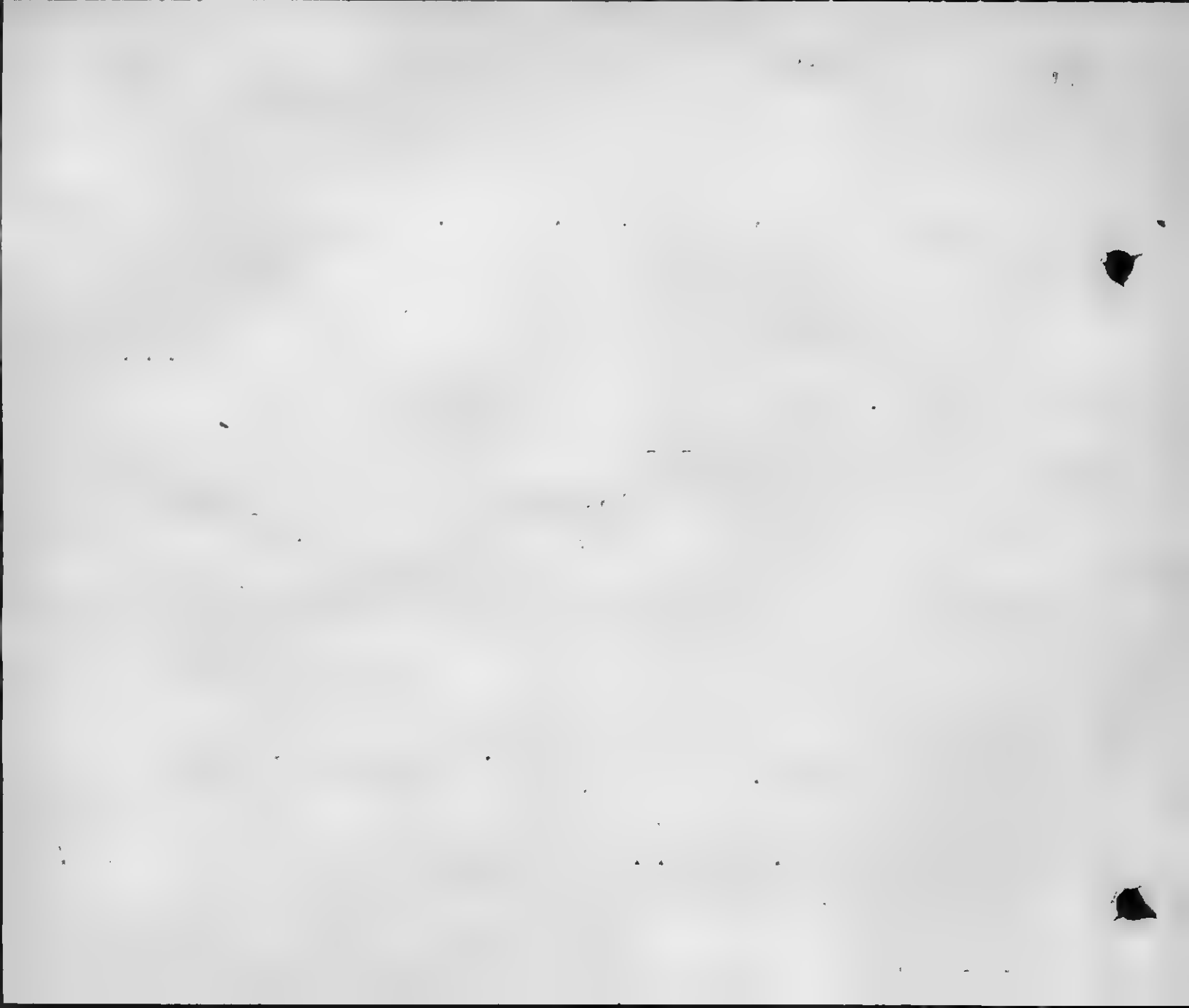
Leesburg, VA

### 25a. REC'D BY REGISTRAR

DATE DEC 8 '61

### 25b. REGISTRAR'S SIGNATURE

James S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

14059  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14027

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u> |  |
| b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>                                       |  |
| c. LENGTH OF STAY IN 1b  |  | d. STREET ADDRESS <u>519 Crabbs Ave.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) <u>Mark Preston Bonner</u>   |  | 4. DATE OF DEATH <u>Dec. 23 1961</u>  |  |
| 5. SEX <u>male</u>   |  | 6. COLOR OR RACE <u>White</u>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>12/24/61</u>  |  |
| 9. AGE (In years last birthday) <u>37</u> yrs.   |  | 10. IF UNDER 1 YEAR Months <u>3</u> Days <u>7</u> Hours <u>54</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>   |  |
| 10b. KIND OF BUSINESS OR INDUSTRY  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>Howard Bonner</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Joyce M. Mc Kinney</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)   |  | 16. SOCIAL SECURITY NO. <u>mother's chart.</u>  |  |
| 17. INFORMANT <u>mother's chart.</u>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Atelectasis</u><br>DUE TO (b) <u>Prematurity</u><br>DUE TO (c)  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)  |  |
| 20c. TIME OF INJURY Month, Day, Year <u>12-23-1961</u><br>Hour a.m. <u>19</u> p.m.   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-21</u> 19 <u>61</u> , to <u>12-23</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12-23</u> 19 <u>61</u> , and that death occurred at <u>PM</u> , from the causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE <u>Francis J. Troendle</u>  |  | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Francis J. Troendle</u>  |  | 22d. ADDRESS <u>809 Viers Mill Rd., Rockville, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>12/26/61</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>   |  | 23d. LOCATION (City, town or county) (State) <u>Gaithersburg, Maryland</u>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>  |  | 25a. REC'D BY REGISTRAR <u>DEC 28 '61</u>   |  |
| 25b. REGISTRAR'S SIGNATURE   |  | 25c. DATE   |  |

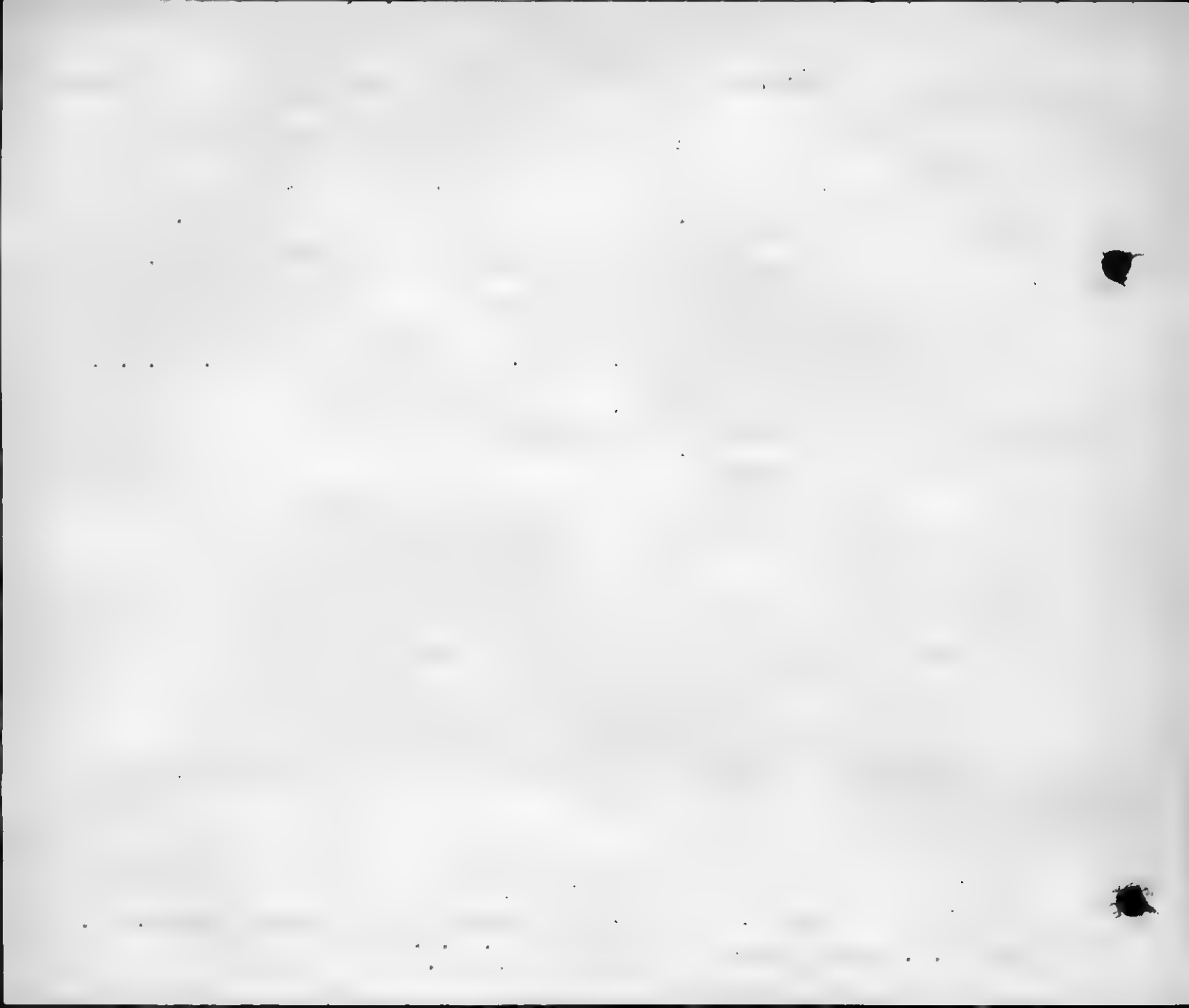
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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|   |                                  |   |                                     |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>8403 Old Georgetown Rd.</b>  |                                  | e. STREET ADDRESS<br><b>8403 Old Georgetown Rd.</b>   |                                     |
| 3. NAME OF DECEASED (Type or print)<br><b>Edward Bowling</b>  |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>12</b> Year <b>1961</b>  |                                     |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/20/78</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Mechanic Capitol Transit Co.</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Fredericksburg, Va. U.S.A.</b>  |                                     |
| 11. BIRTHPLACE (County & State, or foreign country)   |                                  | 12. CITIZEN OF WHAT COUNTRY?  |                                     |
| 13. FATHER'S NAME<br><b>Unknown</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO. <b>?</b>  |                                     |
| 17. INFORMANT<br><b>Florence Bowling</b>  |                                  | Address<br><b>same as #2</b>  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO <b>Coronary atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>Generalized atherosclerosis</b><br>DUE TO <b>Generalized atherosclerosis</b><br>(c) <b>Pulmonary Embolism</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Embolism</b> |                                  |   |                                     |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |                                     |
| 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II. of item 18.)   |                                  |   |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                                  |   |                                     |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                  |   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  |   |                                     |
| 20f. (City or town) (County) (State)  |                                  |   |                                     |
| 21. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>Jan 1, 1940</b> to <b>Dec 12, 1961</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>Dec 10, 1961</b> and that death occurred <b>10:00 AM</b> from the causes and on the date stated above.  |                                  |   |                                     |
| 22a. SIGNATURE <b>Robert E. Maher M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED   |                                  |   |                                     |
| 22c. PHYSICIAN'S NAME (Type) <b>Robert E. Maher M.D.</b> 22d. ADDRESS <b>1835 Eye St. N.W. Wash 6, D.C.</b>   |                                  |   |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b> 23b. DATE THEREOF <b>12/15/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Montgomery County, Md.</b>  |                                  |   |                                     |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company</b> ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b> 25. REC'D BY REGISTRAR <b>DEC 15 '61</b> 25b. REGISTRAR'S SIGNATURE   |                                  |   |                                     |





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14061

## CERTIFICATE OF DEATH

14029

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b <u>1 Month</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oakhaven Convalescent Home</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>8611 Mayfair Place</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Anita</u><br>First Middle Last<br><b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u><br><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>March 28 1887</u><br><b>9. AGE</b> (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months <u>5</u> Days <u>19</u> Hours <u>61</u> Min. |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Hotel Owner</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Uta h</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U. S. A.</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>  |  |
| <b>13. FATHER'S NAME</b> <u>Marcus Pliny Sawtelle</u><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)  |  | <b>14. MOTHER'S MAIDEN NAME</b> <u>Caesaria Armigo</u><br><b>16. SOCIAL SECURITY NO.</b> <u>571-38-7152A</u><br><b>17. INFORMANT</b> <u>Mrs. Emma Watterson (daughter)</u>   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>(b) <u>arteriosclerotic Cardiovascular Disease</u><br>(c) <u>15 yrs.</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).             |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>   |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from April 1, 1961, to Dec 5, 1961, that (I) (we) last saw the deceased alive on Dec 5, 1961, and that death occurred at 3:30 PM, from the causes and on the date stated above.</b>  |  | <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| <b>22a. SIGNATURE</b> <u>George B. Patrick Jr</u><br><b>22c. PHYSICIAN'S NAME (Type)</b> <u>George B. Patrick, Jr M.D.</u>   |  | <b>22b. DATE SIGNED</b> <u>12-5-61</u><br><b>22d. ADDRESS</b> <u>9227 Colesville Rd. Silver Spring, Md.</u>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>   |  | <b>23b. DATE THEREOF</b> <u>12/8/61</u>  |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>FORT LINCOLN MAUSOLEUM</u>  |  | <b>23d. LOCATION (City, town or county)</b> <u>PRINCE GEORGE'S MARYLAND</u>  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond A. Zisk</u><br><b>25a. REC'D BY REGISTRAR</b> <u>DEC 7 '61</u>  |  | <b>25b. REGISTRAR'S SIGNATURE</b> <u>Wm. S. Thomas</u>   |  |

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



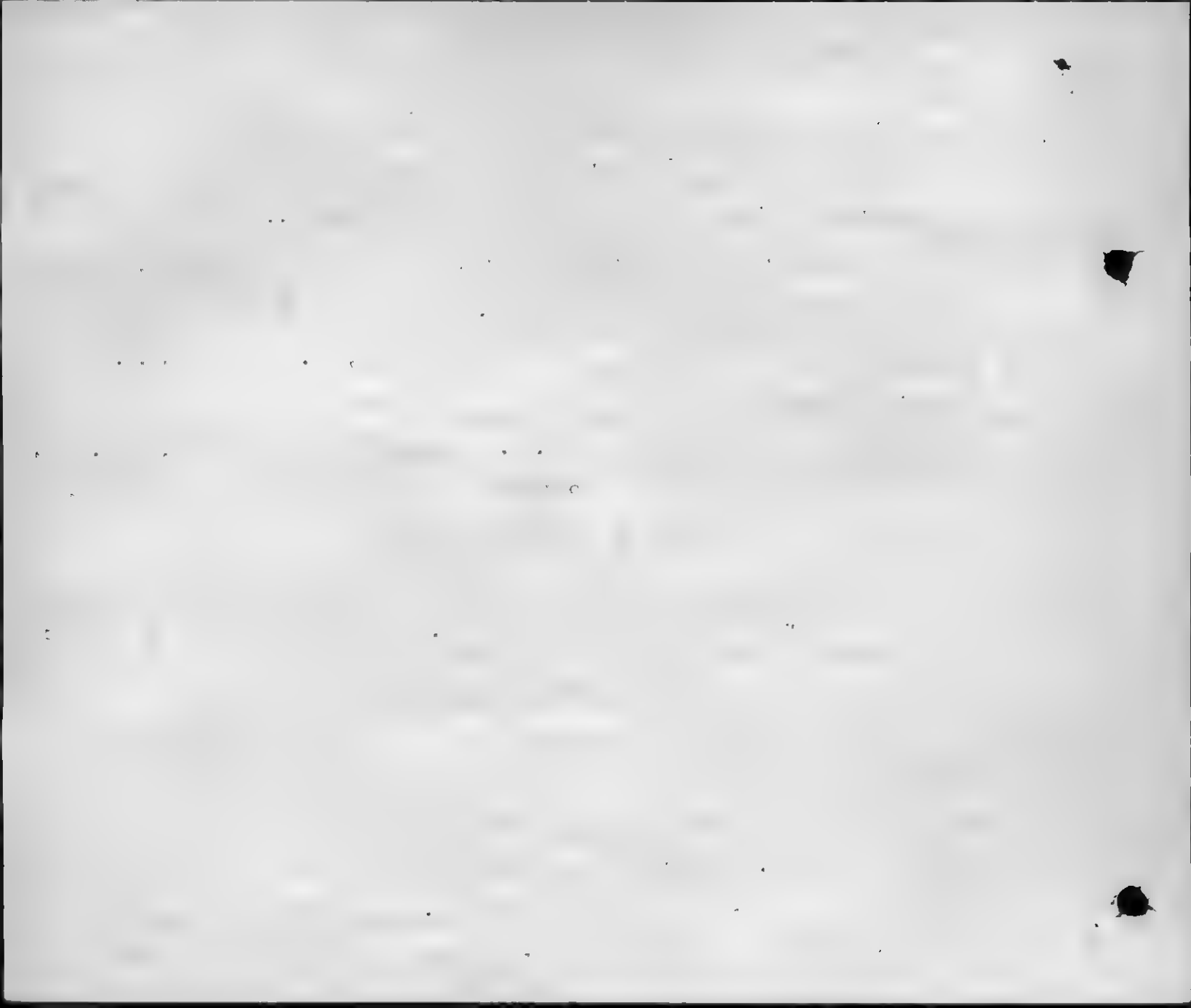
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FOR STATE  
HEALTH DEPT.

14063 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14063 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14030

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b><br>c. LENGTH OF STAY IN 1b <b>1 1/2 hours</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Ohio</b><br>b. COUNTY <b>Rocky River</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>21641 Lake Rd.</b><br>d. STREET ADDRESS <b>21641 Lake Rd.</b> |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Mary Wirsing Bradshaw</b>  |  |   | 4. DATE OF DEATH <b>December 7, 1961</b>   |  |  |
| 5. SEX <b>Female</b>   |  |   | 6. COLOR OR RACE <b>White</b>  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |   | 8. DATE OF BIRTH <b>Jan. 4, 1886</b>   |  |  |
| 9. AGE (In years last birthday) <b>75</b> yrs.   |  |   | 10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>18</b>  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Philadelphica, Pa.</b>  |  |  |
| 11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>  |  |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |
| 13. FATHER'S NAME <b>Christian Tullner</b>   |  |   | 14. MOTHER'S MAIDEN NAME <b>Rosa Engel</b>   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |   | 16. SOCIAL SECURITY NO. <b>Unknown</b>   |  |  |
| 17. INFORMANT <b>Wm. W. Tullner, 5909 Greenlawn Dr., Beth., Md.</b>  |  |   | Address <b>Beth., Md.</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Abdominal hemorrhage</b><br><b>451X</b> DUE TO (b) <b>Rupture of abdominal aneurysm</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>451X</b>  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):<br><b>History of aneurysm the past 5 years.</b>   |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town)  |  | (County)  |  | (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |  |  |
| ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |  |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |  |  |
| Address (Street, city, town, or county) <b>12-7-61</b>   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 12-10-61</b>   |  | 22b. DATE THEREOF <b>12-10-61</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Park Cem.</b>           |  |
| 22d. LOCATION (City, town, or country) <b>Cuyahoga County, Ohio</b>  |  | (State)   |  |  |  |
| 23. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b><br>ADDRESS <b>Bethesda, Md.</b>   |  |   |  |  |  |
| 24a. REC'D BY REGISTRAR <b>DEC 13 '61</b>  |  |   |  |  |  |
| 24b. REGISTRAR'S SIGNATURE <b>S. H. Hume</b>   |  |   |  |  |  |

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 3405 1/8/62 mh

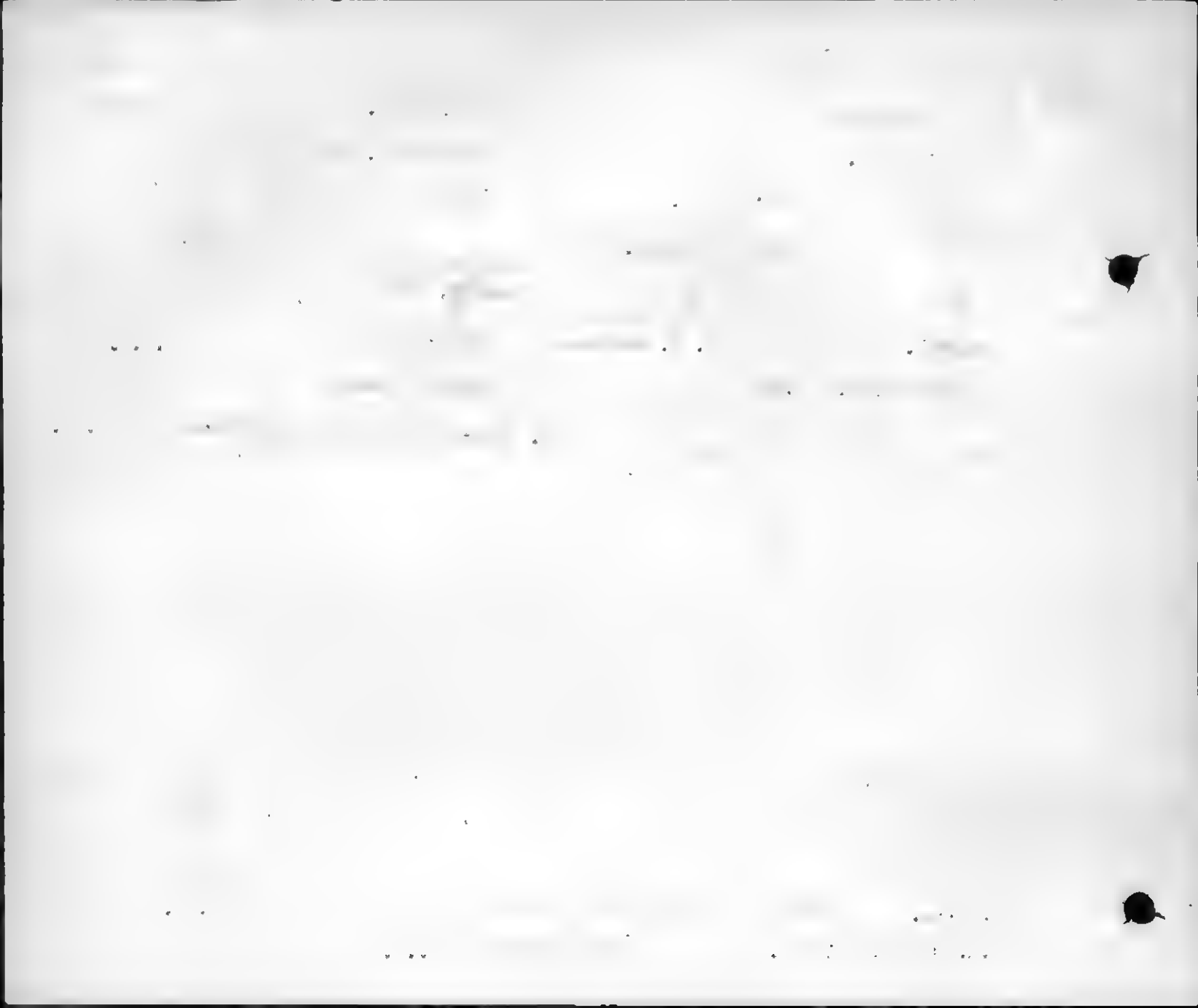
14062

## CERTIFICATE OF DEATH

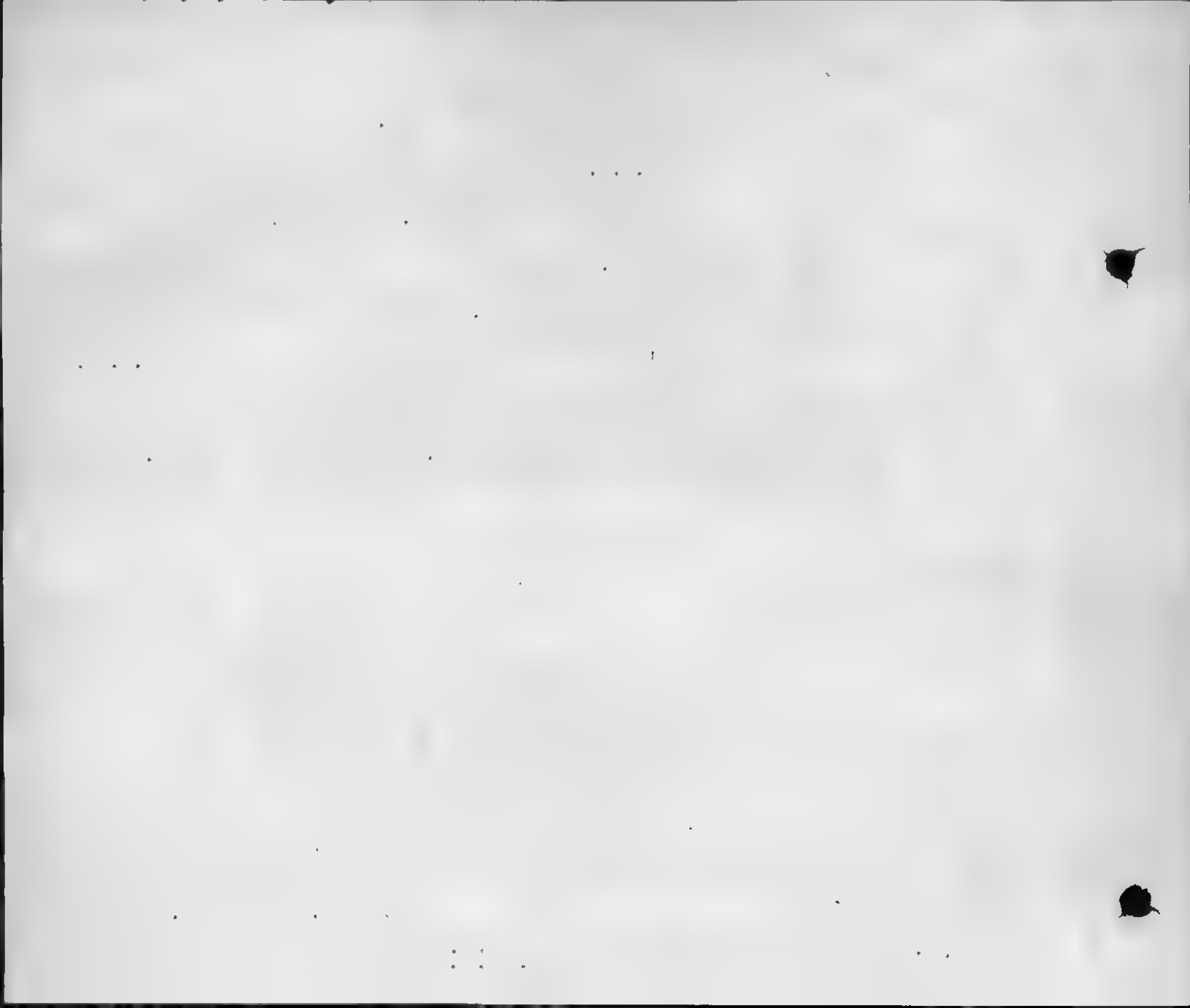
Reg.-Dist. No. **14031**

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>MONTGOMERY</b> <span style="float: right;">MARYLAND</span>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>MONTGOMERY</b></span>   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>KENSINGTON.</b>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>KENSINGTON, MD Washington</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>CARROLL MALL NURSING HOME.</b>  |  |  |  | d. STREET ADDRESS <b>100 Kennedy St., N.E.</b><br><b>10231 Carroll Place</b>  |  |   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <span style="float: right;">First Middle Last</span><br><b>GILBERT B BRADY.</b>  |  |  |  | <b>4. DATE OF DEATH</b><br>Month Day Year<br><b>12/24/61</b>  |  |   |  |
| <b>5. SEX</b><br><b>M</b>  |  | <b>6. COLOR OR RACE</b><br><b>W</b>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br>June 29 1879<br><b>June 29, 1879</b>   |  |
| <b>9. AGE</b> (In years last birthday) yrs.<br><b>82</b>   |  | <b>IF UNDER 1 YEAR</b><br>Months Days Hours Min  |  | <b>IF UNDER 24 HRS.</b><br>Months Days Hours Min  |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>RETIRED.</b> |  |
| <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>D. C. Government</b>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Virginia</b>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |  |   |  |
| <b>13. FATHER'S NAME</b><br><b>Adam Randolph Brady</b>   |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Isabelle Davis</b>  |  |   |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give war or dates of service)   |  |  |  | <b>16. SOCIAL SECURITY NO</b><br><b>INFORMANT</b><br><b>Mr. Randolph B Brady</b>  |  |   |  |
| <b>17. ADDRESS</b><br><b>100 Kennedy St N. E.</b>  |  |  |  | <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio-sclerosis</b><br><b>450.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m.<br>19  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town)</b> (County) (State)   |  |
| <b>21. I certify that I attended the deceased from Oct 30, 1961, to Dec 24, 1961, that I last saw the deceased alive on Dec 23, 1961, and that death occurred at 11 P.M. from the causes and on the date stated above.</b> |  |  |  |   |  |   |  |
| <b>ACTUAL SIGNATURE</b><br><b>A. B. LITTLE</b>   |  |  |  | <b>ADDRESS</b> (Street, city or town, state)<br><b>6911 5th St. NW</b>  |  |   |  |
| <b>PHYSICIAN'S NAME (Type)</b><br><b>A. B. LITTLE</b>  |  |  |  | <b>DATE SIGNED</b><br><b>6911</b>   |  |   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>BURIAL.</b>   |  | <b>22b. DATE THEREOF</b><br><b>12/27/61</b>  |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Mt Olivet Cem</b>   |  | <b>22d. LOCATION (City, town, or county)</b> (State)<br><b>Washington, D. C.</b>                                      |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>W.K. HUNTEMANN &amp; SON.</b>  |  |  |  | <b>24a. REC'D BY REGISTRAR</b><br><b>5732 GEORGIA AVE N.W.</b>  |  | <b>24b. REGISTRAR'S SIGNATURE</b><br><b>Charles E. Thomas</b>   |  |

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased certificate be executed within 24 hours after death. Page 4  
 GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VS. AISME  
5M 9/60

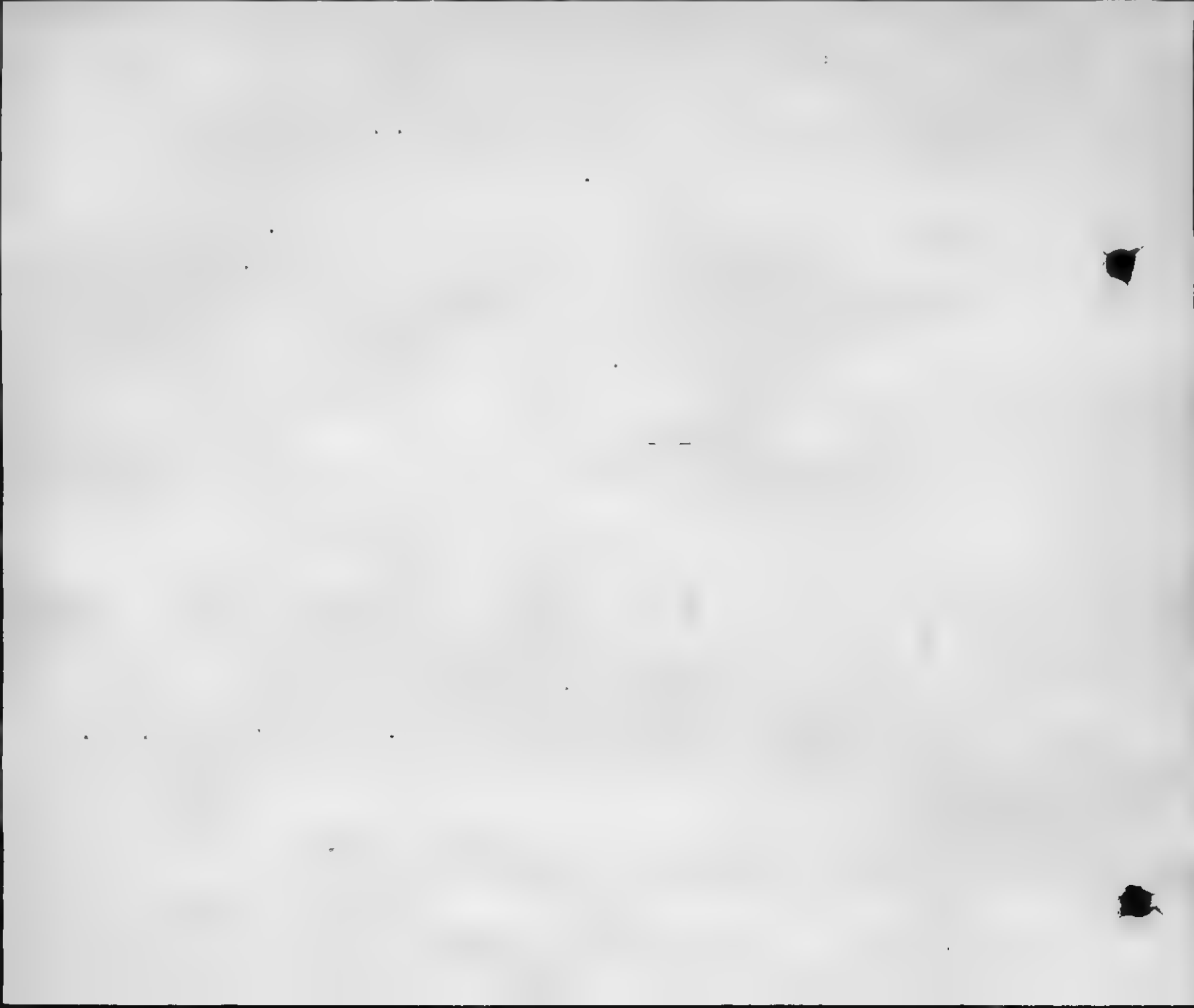




VS. A15ME  
5M 9/60

**EMERGENCY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, the examiner should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**CO-FUNERAL EXAMINER:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, and its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO-HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 2 and 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14066

14034

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN b. <u>193 Days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u> |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Kent</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u><br>d. STREET ADDRESS <u>R.D.#3</u>  |  | <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Regina Gabrielle Brown</u>  |  | <b>4. DATE OF DEATH</b><br>Month <u>December</u> Day <u>23</u> Year <u>19 61</u>   |  |
| <b>5. SEX</b><br><u>Female</u>  |  | <b>6. COLOR OR RACE</b><br><u>White</u>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b><br><u>August 18, 1943</u> |  | <b>9. AGE</b> (In years last birthday) <u>18</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>14</u> Days <u>8</u> <b>IF UNDER 24 HRS.</b> Hours <u>14</u> M. n. <u>8</u> |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Student</u>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>   |  | <b>11. BIRTH PLACE</b> (County & State, or foreign country) <u>Maryland</u>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>  |  |
| <b>13. FATHER'S NAME</b><br><u>Carl Brown</u>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Regina M. Goss</u>   |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>   |  | <b>16. SOCIAL SECURITY NO.</b> <u>None</u>   |  |
| <b>17. INFORMANT</b><br><u>The Medical Records</u>  |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gram negative septicemia</u><br>2.04.2 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastro-intestinal ulceration</u><br>DUE TO<br>(c) <u>Acute myelogenous leukemia</u> |  | <b>19. INTERVAL BETWEEN ONSET AND DEATH</b><br><u>5 Days</u><br><u>7 Days</u><br><u>9 Months</u>   |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <u>pneumonia</u>  |  | <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>19</u>  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town)</b> <u>Chestertown</u>  |  | <b>20g. (County)</b> <u>Md.</u>  |  | <b>20h. (State)</b> <u>Md.</u>   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from June 13, 19 61 to December 23, 19 61 that (I) (we) last saw the deceased alive on December 23, 19 61 and that death occurred at 2:00 PM from the causes and on the date stated above.</b>  |  |  |  |  |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Thorne S. Winter, III, M.D.</u>   |  | <b>22b. ADDRESS</b><br><u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>   |  | <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Thorne S. Winter, III, M.D.</u>  |  | <b>22d. DATE SIGNED</b><br><u>12-23-61</u>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   |  | <b>23b. DATE THEREOF</b><br><u>12/26/61</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Chaster Cemetery</u>   |  | <b>23d. LOCATION</b> (City, town or county) <u>Chestertown, Md.</u>  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Marvin V. Williams</u>  |  | <b>24b. ADDRESS</b><br><u>Chestertown, Md.</u>   |  | <b>25a. REC'D BY REGISTRAR</b><br><u>DEC 28 '61</u>  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Clara S. Kline</u>   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14067

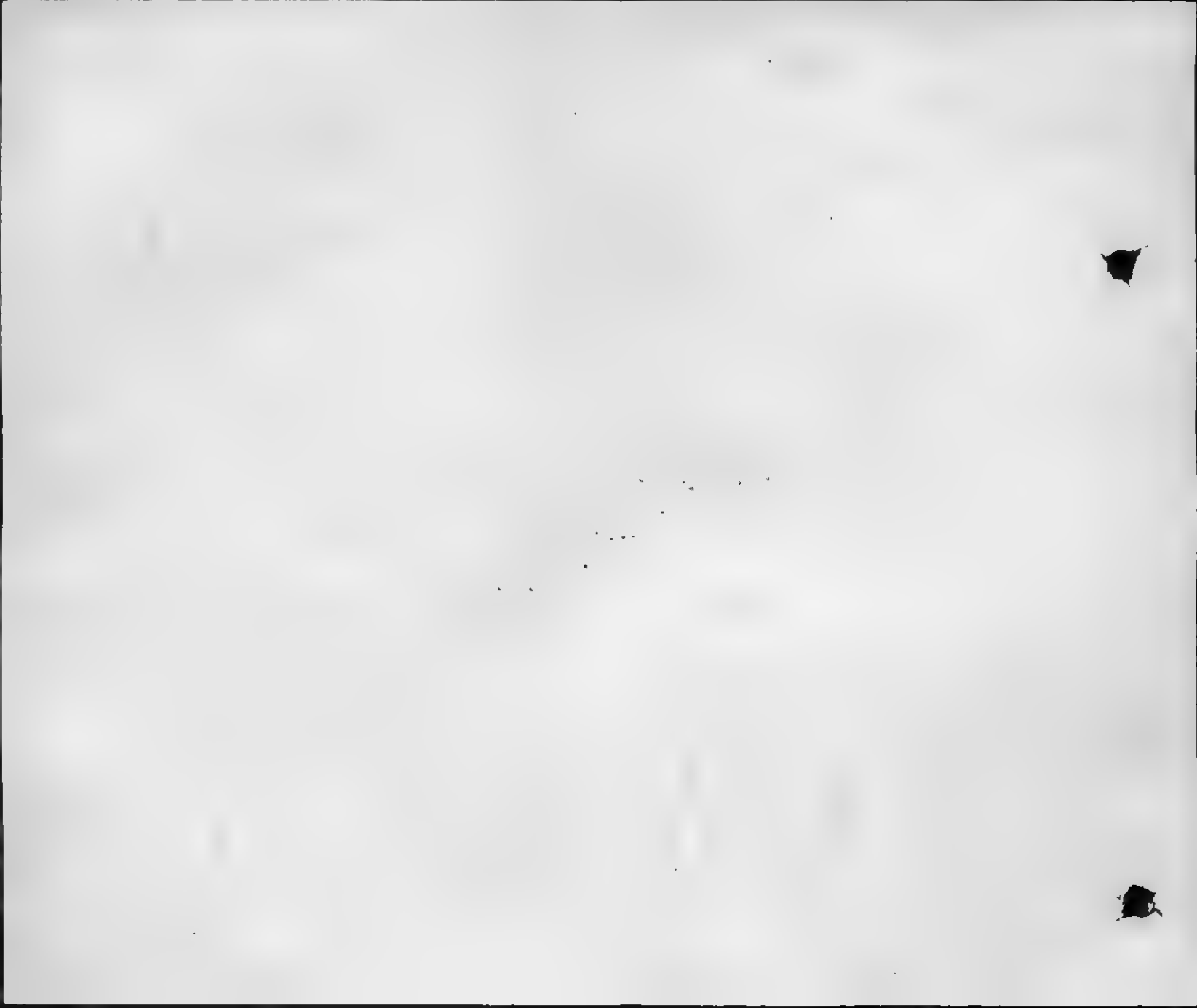
## CERTIFICATE OF DEATH

14035

|  |   |  |  |   |  |  |  |
|--|---|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA Park</u><br>c. LENGTH OF STAY IN 1b <u>1 Monday</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San &amp; Hosp.</u>               |   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u><br>d. STREET ADDRESS <u>1415 RUATAN ST.</u> |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Rose MARY BUNT</u>   |   | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>8</u> Year <u>1961</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 5. SEX <u>FEMALE</u>   | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>MAR. 7-1907</u> | 9. AGE (In years last birthday) <u>54</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>5</u> Days <u>4</u> |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>OHIO</u>   |  |  |  |
| 13. FATHER'S NAME <u>ERNEST Bodeker</u>  |   | 14. MOTHER'S MAIDEN NAME <u>MINNIE Piper</u>   |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |   | 16. SOCIAL SECURITY NO. <u>NO</u>  |  | 17. INFORMANT <u>Hospital Records</u>   |  |  |  |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a) (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>Chemia</u><br>Conditions, if any, which gave rise to immediate cause (b) <u>Chronic renal disease</u><br>(a), stating the underlying cause last. (c) <u>Diabetes mellitus</u> |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 year</u><br><u>unknown</u><br><u>15 years</u>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).   |   |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>19</u><br>p.m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |   |  |  |  |
| 21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>July 17, 1961</u> to <u>Dec. 8, 1961</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Dec. 7, 1961</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.                             |   |  |  |   |  |  |  |
| 22a. SIGNATURE <u>EINO MAGI</u>  |   | 22b. DATE SIGNED <u>12-8-61</u>  |  |   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>  |   | 22d. ADDRESS <u>913 University Blvd. E. Silver Spring, Md.</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>Dec. 11, 1961</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery Prince George's County, Md.</u>   |  | 23d. LOCATION (City, town or county) (State)  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>   |   | 25a. RECEIVED BY REGISTRAR <u>DEC 13 1961</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>C. T. M. S. Knaus</u>   |  |  |  |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14068

## CERTIFICATE OF DEATH

14036

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Olney</b><br>c. LENGTH OF STAY (in day)<br><b>1 day</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Montgomery General Hospital</b> |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Howard</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Clarksville</b><br>d. STREET ADDRESS<br><b>Hallshop Road</b> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Thomas Frank Butler</b>  |   | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>30</b> Year <b>1961</b>  |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>colored</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>1880</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>unemp.</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (Country & State or foreign country)<br><b>Maryland</b> |
| 13. FATHER'S NAME   |   | 14. MOTHER'S MAIDEN NAME  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO<br><b>218-32-3334</b>  |  |
| 17. INFORMANT<br><b>Hospital Records</b>  |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause or, if forced, two, and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Chronic myocardial failure</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Atherosclerotic heart disease</b><br>(c) DUE TO<br>cause last.        |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b><br><b>20 years</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BL<br><b>Nephrosclerosis</b>  |   | TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)<br>(County)<br>(State)                             |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 18, 1961</b> to <b>Dec. 30, 1961</b> , that (I) <b>did</b> last saw the deceased alive on <b>Dec. 30, 1961</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><b>Dr. C.S. Whitaker, M.D.</b>  |   | 22b. DATE SIGNED<br><b>12-31-61</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. C.S. Whitaker</b>  |   | 22d. ADDRESS<br><b>Clarksville, Maryland</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>1-2-1962</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bushy Park</b>   | 23d. LOCATION (City, town or county)<br><b>Glenwood, Md</b>            |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>F.C. Higginsbotham, Ellicott City, Md</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 3 '62</b>  |  |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CONFIDENTIAL  
- Project 100000 -



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

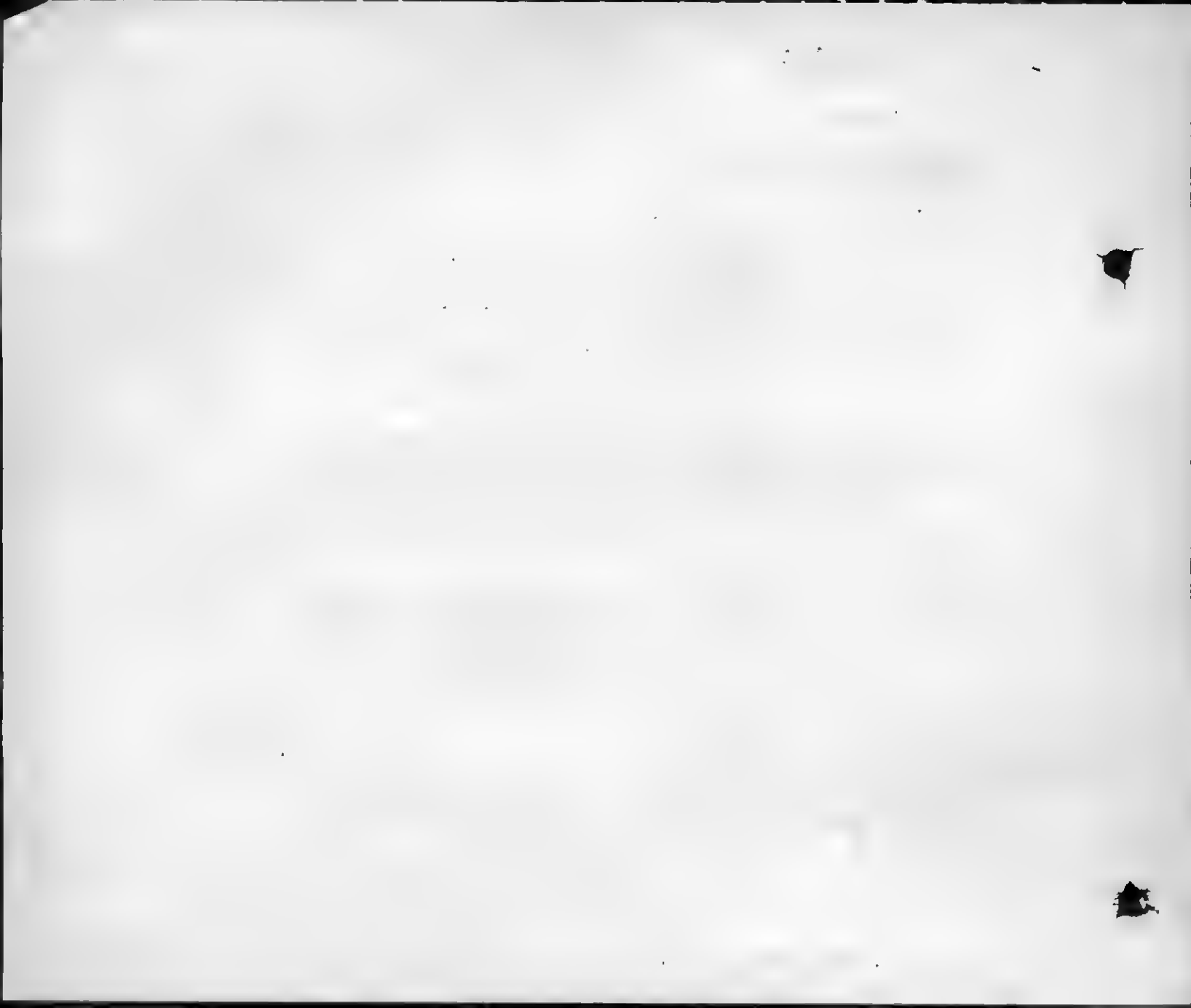
**CERTIFICATE OF DEATH**

14069

14037

|  |                                     |  |  |
|--|-------------------------------------|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda Kensington</b><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Kensington Gardens San.</b> |                                     | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution- Residence before admission)<br>a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Montgomery</b></span><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>d. STREET ADDRESS<br><b>4405 East-West Highway</b> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>Henrietta Kibble Carrick</b>  |                                     | <b>4. DATE OF DEATH</b><br>Month <b>December</b> Day <b>6</b> Year <b>1961</b>   |  |
| <b>5. SEX</b><br><b>F</b>  | <b>6. COLOR OR RACE</b><br><b>W</b> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br><b>Nov. 6, 1880</b>                           |
| <b>9. AGE</b> (In years last birthday) <b>81</b>   |                                     | <b>10. IF UNDER 1 YEAR</b><br>Months <b>1</b> Days <b>0</b>  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                     | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br>-----  |  |
| <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Washington D. C.</b>  |                                     | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>USA</b>  |  |
| <b>13. FATHER'S NAME</b><br><b>Alexandria Kibble</b>   |                                     | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Elizabeth ( Unknown)</b>   |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no or unknown, (If yes, give war or dates of service))<br><b>No</b>   |                                     | <b>16. SOCIAL SECURITY NO.</b><br><b>578-30-6117B</b>  |  |
| <b>17. INFORMANT</b><br><b>Elmer Carrick-Husband-same 2d</b>   |                                     |  |  |
| <b>18. CAUSE OF DEATH</b> {Enter only one cause per line for (a), (b), and (c)}<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b><br>(b) <b>Cerebral arteriosclerosis.</b><br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>31X</b>                              |                                     |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>Immediate.</b><br><b>?</b> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Inanition.</b>   |                                     |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     | <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>   |  |
| <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |                                     | <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour o. m. p. m. 19   |  |
| <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                     | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  |
| <b>20f. (City or town)</b>   |                                     | <b>(County)</b>  |  |
| <b>(State)</b>   |                                     | <b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>56 Dec. 6, 1961</b> <b>to</b> <b>11-30-1961</b> <b>that (I) (we) lost</b> <b>the deceased alive on</b> <b>11-30-1961</b> <b>and that death occurred at</b> <b>5 PM</b> <b>from the causes and on the date stated above.</b>  |  |
| <b>22a. SIGNATURE</b><br><b>George A. Gray, Jr.</b>  |                                     | <b>22b. DATE SIGNED</b><br><b>12/6/61</b>  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><b>GEORGE A. GRAY, JR., MD.</b>   |                                     | <b>22d. ADDRESS</b><br><b>4740 Chevy Chase Dr. Chevy Chase, Md.</b>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>  |                                     | <b>23b. DATE THEREOF</b><br><b>12/8/61</b>   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Rock Creek Cemetery</b>  |                                     | <b>23d. LOCATION (City, town, or county)</b><br><b>Washington, D. C.</b>   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Robert A. Pumphrey, Bethesda, Maryland</b>   |                                     | <b>25a. REC'D BY REGISTRAR</b><br><b>DEC 8 1961</b>  |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><b>[Signature]</b>  |                                     | <b>DATE</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

14070

1-1038

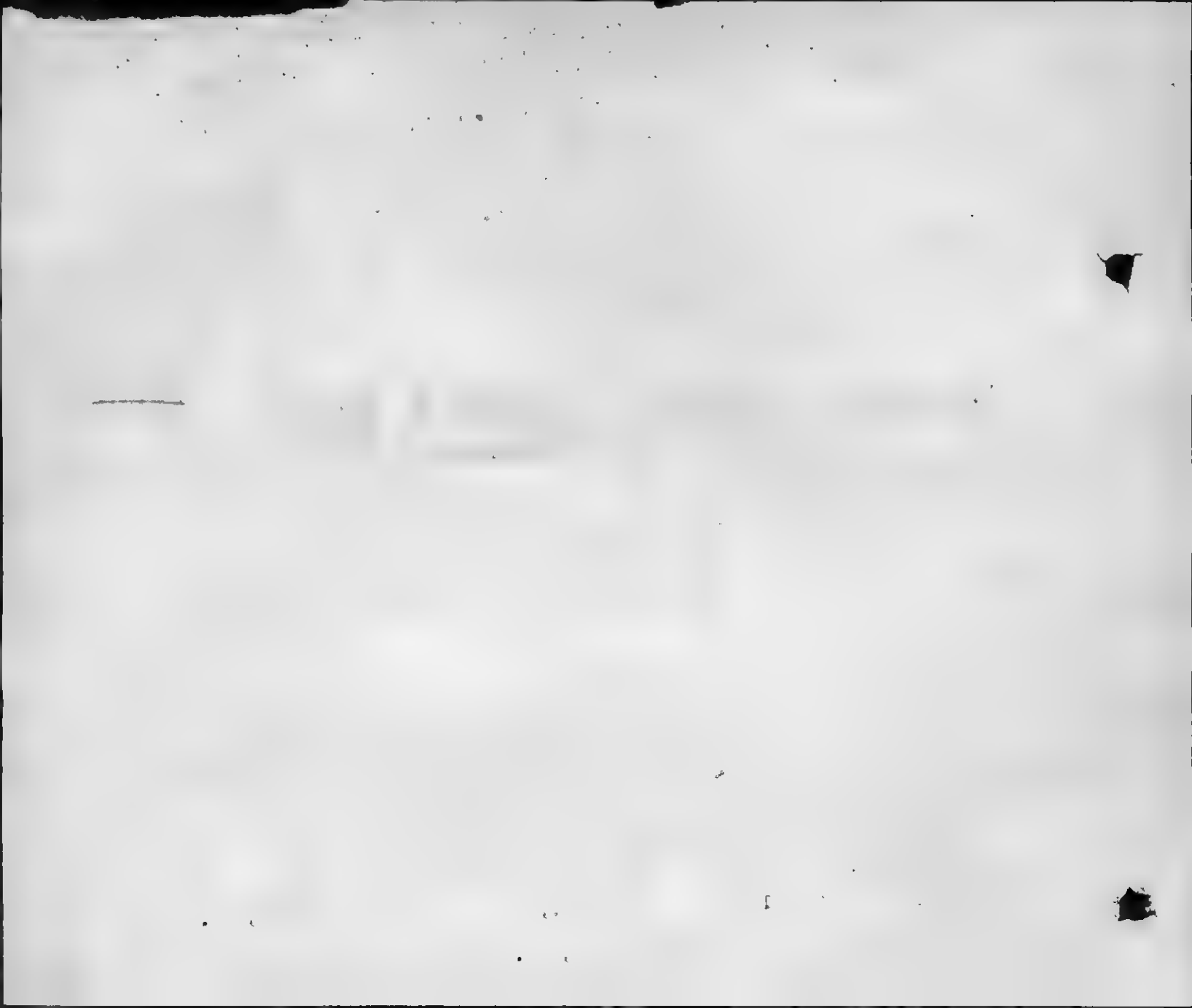
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|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <small>MARYLAND</small>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Mont. Co.</u>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  | c. LENGTH OF STAY IN 1b <u>2 1/2 days</u>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital; give street address) OR INSTITUTION <u>Suburban</u>  |   | d. STREET ADDRESS <u>618 - Monroe St.</u>  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Owen B.</u> Middle <u>Catron</u> Last <u></u>   |   | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>9</u> Year <u>1961</u>  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 11, 1900</u>  |
| 9. AGE (In years last birthday) <u>61</u> yrs   |   | IF UNDER 1 YEAR  | IF UNDER 24 HRS  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>  | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>  |
| 13. FATHER'S NAME <u>David Catron</u>   |   | 14. MOTHER'S MAIDEN NAME <u>J. Anna Harrison</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> If yes, give war or dates of service <u></u>   |   | 16. SOCIAL SECURITY NO. <u></u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Cerebral Lues</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u></u> DUE TO <u></u><br>(c) <u></u> |   | INTERVAL BETWEEN ONSET AND DEATH <u>years</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>   | 20f. (City or town) (County) (State) <u></u>   |
| 21. I certify that I attended the deceased from <u>12/6/61</u> to <u>12/9/61</u> , that I last saw the deceased alive on <u>12/9/61</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.  |   |  |  |
| ACTUAL SIGNATURE <u>John J. Curry</u> M.D.  |   | ADDRESS (Street, city or town, state) <u>12620 Georgia Ave. Rockville, Md.</u>   |  |
| PHYSICIAN'S NAME (Type) <u>John J. Curry</u>  |   | DATE SIGNED <u>12/9/61</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>12/12/61</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>   | 22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Heeler Funeral Home-1551 E. Montg. Ave. Rockville, Maryland</u>   |   | 24a. REC'D BY REGISTRAR <u>DEC 13 '61</u>  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VS. A15MI  
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## MEDICAL CERTIFICATION



1  
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                      |  |   |  |   |  |  |                                     |   |  |
|---|--|--------------------------------------|--|---|--|---|--|--|-------------------------------------|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                      |  |   |  |   |  |  |                                     |   |  |
| 14072 CERTIFICATE OF DEATH 14040  |  |                                      |  |   |  |   |  |  |                                     |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN b. <u>MARYLAND</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>  |  |                                      |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u><br>d. STREET ADDRESS <u>16X Patuxent Research Refuge,</u> |  |   |  |  |                                     |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Clark</u>  |  |                                      |  | 4. DATE OF DEATH<br>Month Day Year<br><u>December 10, 1961</u>  |  |   |  | 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.<br>yrs. Months Days Hours Min.<br><u>90</u> |                                     |   |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>        |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><u>December 10, 1961</u>  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>no</u>     |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>no</u>      |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>   |  |                                      |  | 12. CITIZEN OF WHAT COUNTRY? <u>America</u>   |  |   |  | 13. FATHER'S NAME<br><u>Gordon Marston Clark</u>   |                                     |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>  |  |                                      |  | 16. SOCIAL SECURITY NO. <u>no</u>   |  |   |  | 17. INFORMANT<br><u>father</u>   |                                     |   |  |
| 18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Immaturity - 26 wks. gestation</u><br>776X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH <u>9.0 minutes</u>   |  |                                      |  |   |  |   |  |  |                                     |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |                                      |  |   |  |   |  |  |                                     |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.  |  |                                      |  |   |  |   |  |  |                                     |   |  |
| 22a. SIGNATURE<br><u>Valgene M. Milstead</u><br>22c. PHYSICIAN'S NAME (Type)<br><u>Valgene M. Milstead, M. D.</u>   |  |                                      |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22d. ADDRESS<br><u>1110 Spring St., Silver Spring, Md.</u> |  |  | 22b. DATE SIGNED<br><u>12/10/61</u> |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>   |  | 23b. DATE THEREOF<br><u>12-11-61</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Washington Sanitarium and Hospital, Takoma Park, Md.</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Silver Spring, Md.</u>   |  | 25a. REC'D BY REGISTRAR<br><u>Robert A. Hare</u>   |                                     | 25b. REGISTRAR'S SIGNATURE<br><u>Robert A. Hare</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Hare, M. D. Washington San. &amp; Hospital</u>   |  |                                      |  |   |  |   |  |  |                                     |   |  |

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ISM 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. The law requires that the death certificate be executed within 24 hours after the death. The law requires that the death certificate be executed within 24 hours after the death.

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MEDICAL CERTIFICATION

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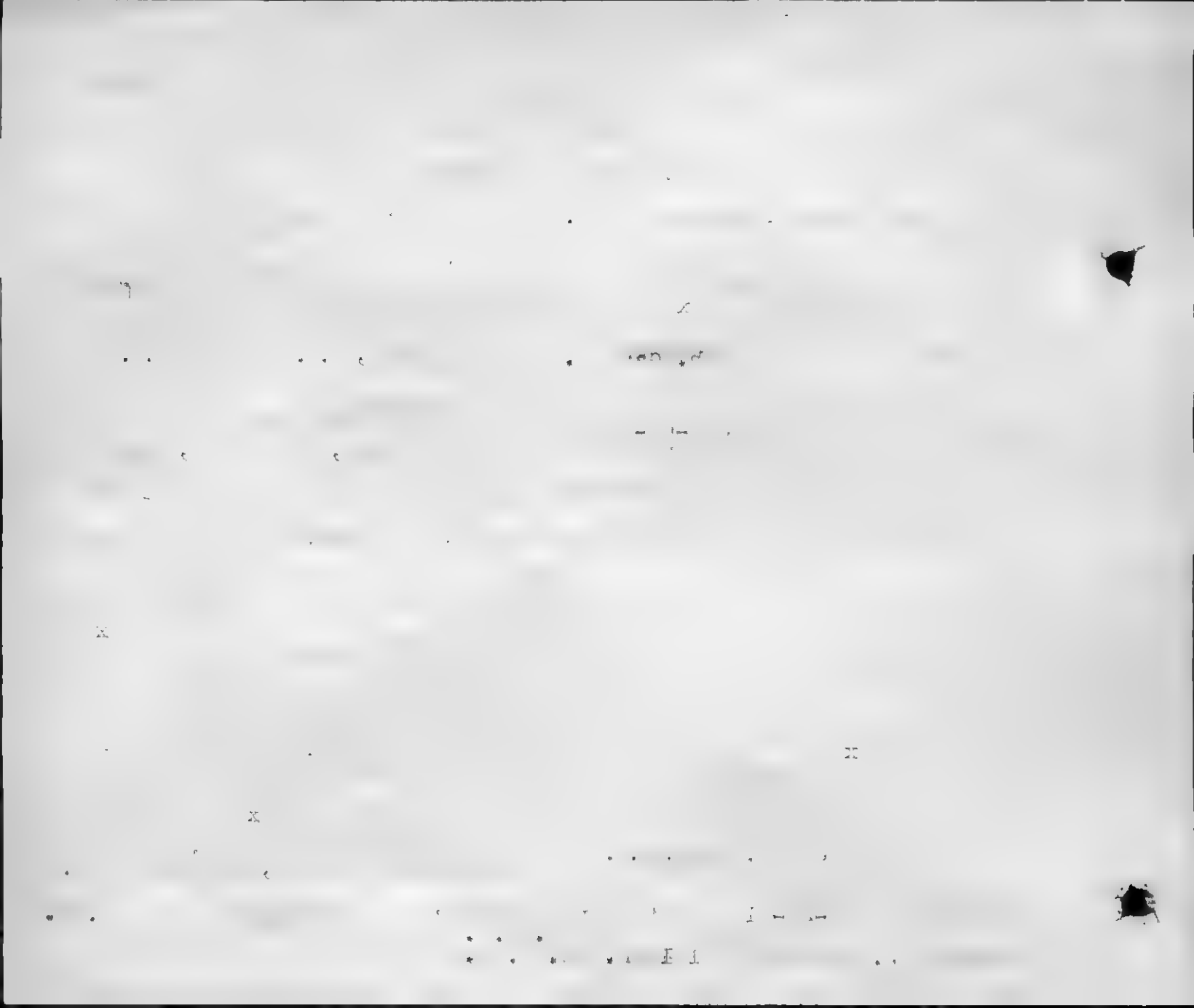
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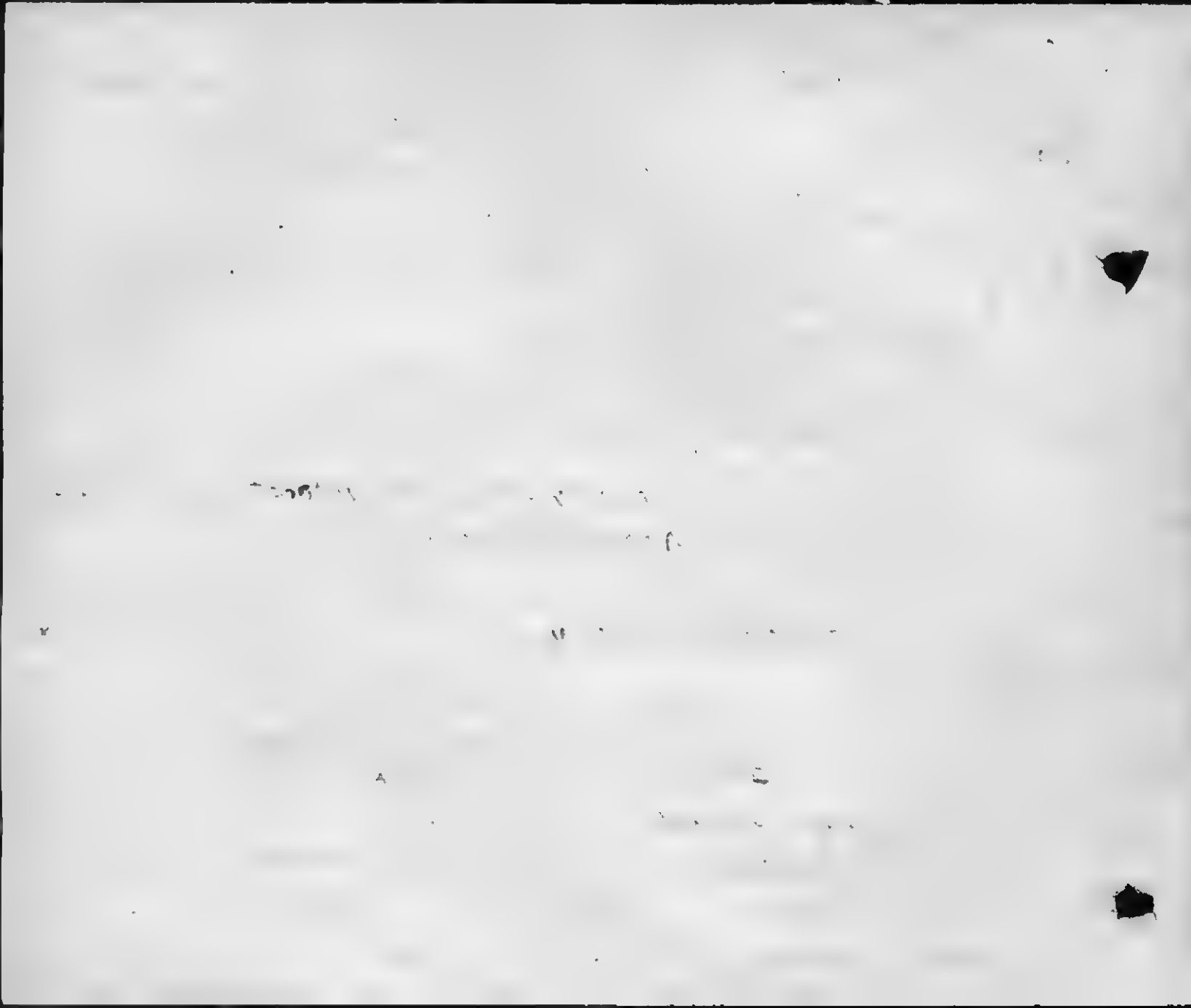
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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14074  
14042  
CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u><br>c. LENGTH OF STAY IN IT <u>3 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN</u>          |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u><br>d. STREET ADDRESS <u>9409 SINGLETON DR.</u>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>KATHERINE M CLEMENTS</u><br>5. SEX <u>F</u><br>6. COLOR OR RACE <u>W</u><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                      |  | 4. DATE OF DEATH<br><u>Dec. 3 1961</u><br>8. DATE OF BIRTH <u>July 6 - 1905</u><br>9. AGE (in years last birthday) <u>56</u> yrs. <u>4</u> months <u>27</u> days <u>18</u> hours <u>18</u> min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>govt</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>Supervisor</u><br>11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u><br>12. CITIZEN OF WHAT COUNTRY <u>USA</u>                 |  | 13. FATHER'S NAME <u>George A Bessler</u><br>14. MOTHER'S MAIDEN NAME <u>Regina A Scott</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u><br>16. SOCIAL SECURITY NO. <u>579-01-9769</u><br>17. INFORMANT <u>Henry E Clements</u> Address <u>same</u>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion &amp; Intoxication.</u><br>Conditions, if any, which gave rise to immediate cause (b) <u>Arterio Sclerosis.</u><br>(c) <u>Due to</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Bronchial Asthma.</u> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20c. TIME OF INJURY<br>Hour <u>19</u> m. <u>19</u><br>p.m. <u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> , 19 <u>61</u> , to <u>date</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>30 Dec</u> , 19 <u>61</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above. |  |  |  |
| 22a. SIGNATURE <u>John G. Ball</u><br>22c. PHYSICIAN'S NAME (Type) <u>John G. Ball</u>   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22d. ADDRESS <u>7936 Old Georgetown Rd. Beth. Md.</u><br>22b. DATE SIGNED <u>12/3/61</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u><br>23b. DATE THEREOF <u>12/6/61</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u><br>23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u><br>25a. REC'D BY REGISTRAR <u>DEC 6 '61</u><br>25b. REGISTRAR'S SIGNATURE <u>Calvin S. Lewis</u>  |  |  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

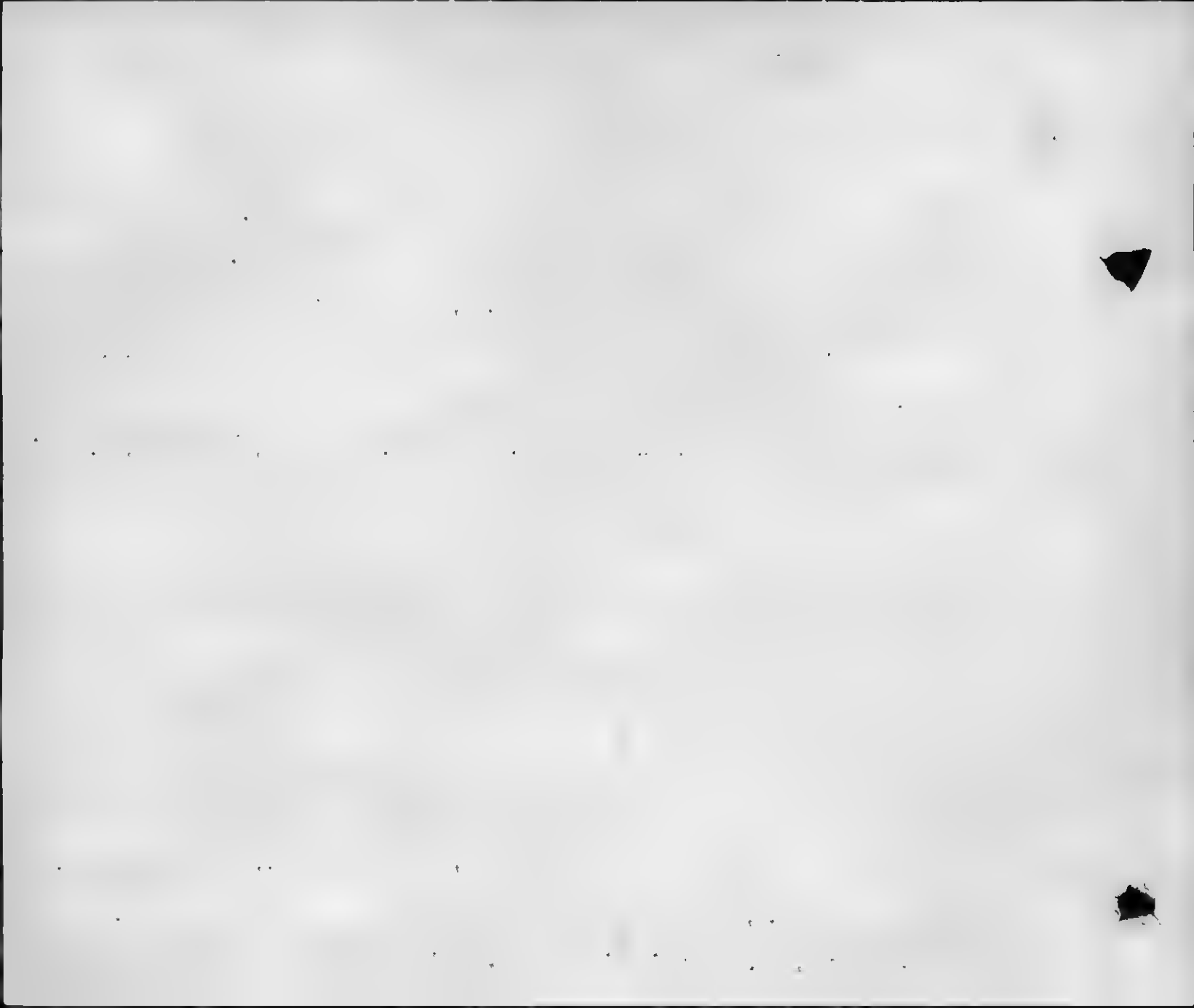
## CERTIFICATE OF DEATH

14075

14043

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashton</u><br>c. LENGTH OF STAY IN 1b <u>3 months</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Belmont Nursing Home</u> |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>43 Kensington</u><br>d. STREET ADDRESS <u>4406 Brookfield Dr.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>FRANK STANLEY CONSTABLE</u>  |  |   |  | 4. DATE OF DEATH <u>Dec. 29 1961</u>  |  |   |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <u>Oct. 4, 1888</u>                                |  |
| 9. AGE (In years last birthday) <u>73</u>   |  | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u>  |  | IF UNDER 24 HRS.<br>Hours <u>0</u> Min. <u>0</u>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance -DC Transit</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME <u>George W. Constable</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Lucy Horsman</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  |   |  | 16. SOCIAL SECURITY NO. <u>578-10-6144A</u>   |  | 17. INFORMANT <u>Mrs. Madeline C. Vierbuchen, Kensington, Md.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial infarction</u><br>DUE TO <u>coronary occlusion</u><br>DUE TO <u>generalized arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.                                      |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>19</u><br>p.m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/23/61</u> to <u>12/29/61</u> , that (I) (we) last saw the deceased alive on <u>12/18/61</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.   |  |   |  |   |  |   |  |
| 22a. SIGNATURE <u>Donald Nelson</u>   |  |   |  | 22b. DATE SIGNED <u>12/29/61</u>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Donald Nelson</u>   |  |   |  | 22d. ADDRESS <u>10,620 Georgia Ave., Silver Spring, Md.</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE THEREOF <u>Jan. 2, 1962</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>   |  | 23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Ziska</u><br>ADDRESS <u>8434 Ga. Ave., Silver Spring, Md.</u><br>Warner E. Pumphrey, Inc.  |  |   |  | 25a. REC'D BY REGISTRAR <u>JAN 4 '62</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>                  |  |

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE FILED WITHIN 24 HOURS AFTER THE DEATH. THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE FILED WITHIN 24 HOURS AFTER THE DEATH. THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE FILED WITHIN 24 HOURS AFTER THE DEATH.



**TOTAL HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after the death. The law requires that the death certificate be executed within 24 hours after the death. The law requires that the death certificate be executed within 24 hours after the death.

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15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

|  |                                     |  |   |
|--|-------------------------------------|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u><br>c. LENGTH OF STAY IN MD <u>MARYLAND</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Residence</u>   |                                     | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>3344 22-Independence St</u><br>d. STREET ADDRESS <u>Rockville - Md</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>RUTH C COOPER</u>   |                                     | <b>4. DATE OF DEATH</b><br><u>Dec 31 1961</u>  |   |
| <b>5. SEX</b><br><u>F</u>  | <b>6. COLOR OR RACE</b><br><u>W</u> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  | <b>8. DATE OF BIRTH</b><br><u>Oct. 18, 1891</u> |
| <b>9. AGE</b> (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |                                     | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Rock - Maryland - Va -</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>  </u>  |   |
| <b>13. FATHER'S NAME</b><br><u>Rosenberger</u>   |                                     | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Martha</u>   |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>W</u> (If yes give year or dates of service) <u>220-09-3336</u>  |                                     | <b>16. SOCIAL SECURITY NO.</b> <u>220-09-3336</u> <b>17. INFORMANT</b> <u>Lorraine Myer</u> Address <u>1437 Independence St Rockville - Md</u>   |   |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br><u>420</u> DUE TO (b) <u>Hypertensive Heart Disease</u><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>  </u> DUE TO (c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> |                                     |  |   |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |  |   |
| <b>20a. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |                                     | <b>20b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| <b>20c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>  |                                     | <b>20d. (City or town)</b> <u>  </u> <b>(County)</b> <u>  </u> <b>(State)</b> <u>  </u>  |   |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>March 1958</u> <b>to</b> <u>Dec 31, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Dec 31, 1961</u> , <b>and that death occurred at</b> <u>11:30 PM</u> , <b>from the causes and on the date stated above.</b>  |                                     |  |   |
| <b>22a. SIGNATURE</b><br><u>Abraham W Danish MD</u>  |                                     | <b>22b. ADDRESS</b><br><u>1106 Spring St. Silver Spring</u>  |   |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>ABRAHAM W DANISH MD</u>  |                                     | <b>22d. DATE SIGNED</b><br><u>1-1-62</u>   |   |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>  |                                     | <b>23b. DATE THEREOF</b><br><u>Jan 4, 1962</u>   |   |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>The Mount Carmel Cemetery</u>  |                                     | <b>23d. LOCATION</b> (City, town or county) <u>Rockville, Md.</u>  |   |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Arthur Patterson</u>   |                                     | <b>25a. REC'D BY REGISTRAR</b> <u>  </u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>   |   |
| <b>25c. ADDRESS</b><br><u>254 Carroll St. N.E.</u>   |                                     | <b>25d. DATE</b><br><u>JAN 3 '62</u>   |   |

*Arthur Patterson*





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

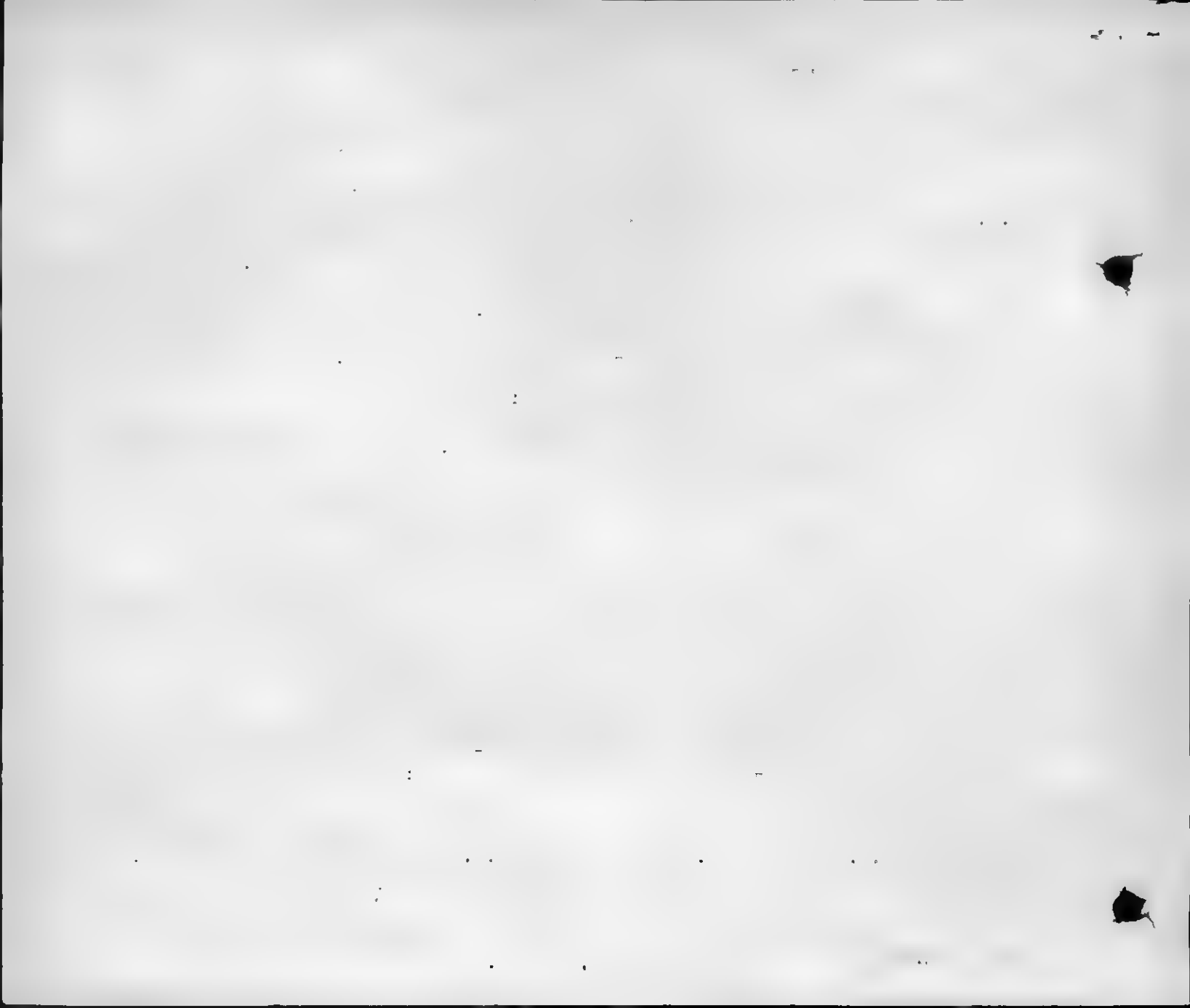
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14077

14045

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 17</u>   |  |
| c. LENGTH OF STAY IN lb <u>27 days</u>  |  | d. STREET ADDRESS <u>516 Domer Ave, Apt. # 3</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital, Bethesda, Md.</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Darwin (n)</u>   |  | 4. DATE OF DEATH <u>Dec. 8 1961</u>  |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>Caucasian</u>  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <u>Jan. 1910</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Andrew CORSO</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Laura MATTEA</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes WW II</u>   |  | 16. SOCIAL SECURITY NO. <u>UNK</u>   |  |
| 17. INFORMANT (W) Edith M. CORSO  |  | Address Same as #2 above   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus</u><br>150X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>150X</u><br>(a), stating the underlying cause last. DUE TO (c) <u>150X</u> |  | INTERVAL BETWEEN ONSET AND DEATH <u>—</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>pneumonia</u>   |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11-10-61</u> 19 <u>61</u> , to <u>12-8</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12-8</u> 19 <u>61</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.                          |  | 22a. SIGNATURE <u>J.W. Brackett Jr.</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>12-8-61</u> |  |
| 22c. PHYSICIAN'S NAME (Type) <u>J.W. BRACKETT JR. LT MC USN</u>   |  | 22d. ADDRESS <u>U.S. NAVAL HOSPITAL, BETHESDA, MARYLAND</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 23b. DATE THEREOF <u>12-12-61</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>  |  | 23d. LOCATION (City, town or county) (State) <u>ARLINGTON VIRGINIA</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME</u> ADDRESS <u>7400 GEORGIA AVE, SS, MD.</u>   |  | 25a. REC'D BY REGISTRAR <u>DEC 11 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thacker</u>  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14078

## CERTIFICATE OF DEATH

14046

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|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11121 Newport Mill Road</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u><br>d. STREET ADDRESS <u>11121 Newport Mill Road</u> |  |
| 3. NAME OF DECEASED (Type or print) <u>Carol Louis Cox</u>   |  | 4. DATE OF DEATH <u>December 16 1961</u>   |  |
| 5. SEX <u>Male</u>   |  | 6. DATE OF BIRTH <u>2/21/1887</u>  |  |
| 6. COLOR OR RACE <u>White</u>  |  | 7. AGE (In years last birthday) <u>74</u> yrs. <u>9</u> months <u>15</u> days  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. IF UNDER 1 YEAR <u>1</u> Hours <u>15</u> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book seller</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Books</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Charles P. Cox</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>102-28-4973</u>   |  |
| 17. INFORMANT <u>Robert R. Cox-Son-same 2d</u>   |  | Address  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Recurrent Pleural Effusion</u><br><u>Chronic Heart Failure - Post Coronary</u><br>PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 hr</u><br><u>1 year</u><br><u>2 year</u> |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  | 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>March</u> <u>1961</u> to <u>16 Dec</u> <u>1961</u> . That (I) ( <del>we</del> ) last saw the deceased alive on <u>16 Dec</u> <u>1961</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE <u>Ann M. Dimitroff</u> M.D.  |  | 22b. DATE SIGNED <u>12/16/61</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Ann M. Dimitroff</u>   |  | 22d. ADDRESS <u>11300 Woodson Avenue, Kens, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 12/18/61</u>   |  | 23b. DATE THEREOF <u>12/18/61</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Wood Lawn Cemetery</u>   |  | 23d. LOCATION (City, town or county) (State) <u>New York, New York</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>   |  | 25a. REC'D BY REGISTRAR <u>DEC 21 '61</u>  |  |
| 25b. REGISTRAR'S SIGNATURE <u>John S. Hines</u>  |  |  |  |



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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14079

CERTIFICATE OF DEATH

14047

|  |                                  |   |                                   |
|--|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u></u>                              |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>  |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington Sanitarium &amp; Hospital</u>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Nellie</u> Middle <u>Alberta</u> Last <u>Cox</u>   |                                  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>15</u> Year <u>1961</u>  |                                   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>2-1-76</u> |
| 9. AGE (In years last birthday)<br><u>85</u> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <u></u> Days <u></u>  |                                   |
| 11. IF UNDER 24 HRS.<br>Hours <u></u> Min. <u></u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  |                                   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Va.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                   |
| 13. FATHER'S NAME<br><u>John W. Taylor</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Tabertha Suttle</u>  |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u></u>  |                                   |
| 17. INFORMANT<br><u>Washington Sanitarium &amp; Hospital Records</u>   |                                  | Address<br><u></u>  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCT? DUE TO:</u><br><u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u></u><br>(c) <u></u><br>DUE TO<br>(e), stating the underlying cause last. |                                  |   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS ; ABDOMINAL AORTIC ANEURYSM ; CARCINOMA OF BREAST.</u>  |                                  |   |                                   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u></u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>NOV. 28</u> , 19 <u>61</u> , to <u>DEC. 15</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12-14</u> , 19 <u>61</u> , and that death occurred at <u>12-15-61</u> from the causes and on the date stated above.   |                                  |   |                                   |
| 22a. SIGNATURE<br><u>Dwight R. Smith</u>   |                                  | 22b. DATE SIGNED<br><u>12-15-61</u>   |                                   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>DWIGHT R. SMITH, M.D.</u>   |                                  | 22d. ADDRESS<br><u>1015 SPRING ST. SILVER SPRING, MD</u>  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>12-18-61</u>  |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Taylor Mem Cem</u>  |                                  | 23d. LOCATION (City, town or county) (State)<br><u>Colonial Beach Va</u>  |                                   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Deaf Funeral Home</u>   |                                  | 25a. REC'D BY REGISTRAR<br><u>4812 So. Ave NW</u>   |                                   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Worth DC</u>  |                                  | 25c. DATE<br><u>DEC 21 '61</u>  |                                   |



**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**CHIEF MEDICAL EXAMINER:** This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

**CHIEF FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

**CHIEF DESIGNATED AGENT:** This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14-00000  
14-080 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7 & 14 Film G304 12/20/61 iwk

14048

|  |                                  |   |                                    |  |
|--|----------------------------------|---|------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Montgomery</u>  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><u>Maryland</u><br>b. COUNTY<br><u>Montgomery</u>  |                                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>   |                                  | c. LENGTH OF STAY IN lb<br><u>55 min</u>  |                                    |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Washington San + Hosp.</u>  |                                  | e. STREET ADDRESS<br><u>1805 Seekers Lane</u>   |                                    |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Ruth Esther Crum</u>  |                                  | 4. DATE OF DEATH<br>Month <u>Dec</u> Day <u>10</u> Year <u>1961</u>   |                                    |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>9-24-97</u> |  |
| 9. AGE (In years last birthday)<br><u>64</u> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <u>6</u> Days <u>4</u>  |                                    |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Pennsylvania</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |                                    |  |
| 13. FATHER'S NAME<br><u>John Albright</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth unknown</u>  |                                    |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>Pr's Chart</u>  |                                    |  |
| 17. INFORMANT<br><u>Pr's Chart</u>   |                                  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertension</u><br>DUE TO (c) _____ |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr.</u><br><u>?</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |                                  |   |                                    |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                    |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                    |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |                                    |  |
| ACTUAL SIGNATURE<br><u>Frank J. Blaszczak</u>  |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                    |  |
| EXAMINER'S NAME (Type)<br><u>FRANK J. Blaszczak</u>  |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                    |  |
| 22a. BURIAL, CREMATION, or other disposal (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>Dec. 1961</u>   |                                    |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>St. Elizabeth Cemetery</u>  |                                  | 22d. LOCATION (City, town, or country) (State)<br><u>Frederick, Maryland</u>  |                                    |  |
| 23. FUNERAL DIRECTOR<br><u>Arthur Walters</u>  |                                  | 24a. REC'D BY REGISTRAR<br><u>EC 15 '61</u>   |                                    |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>1 S. H. H.</u>  |                                  | 24c. REGISTRAR'S SIGNATURE  |                                    |  |





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

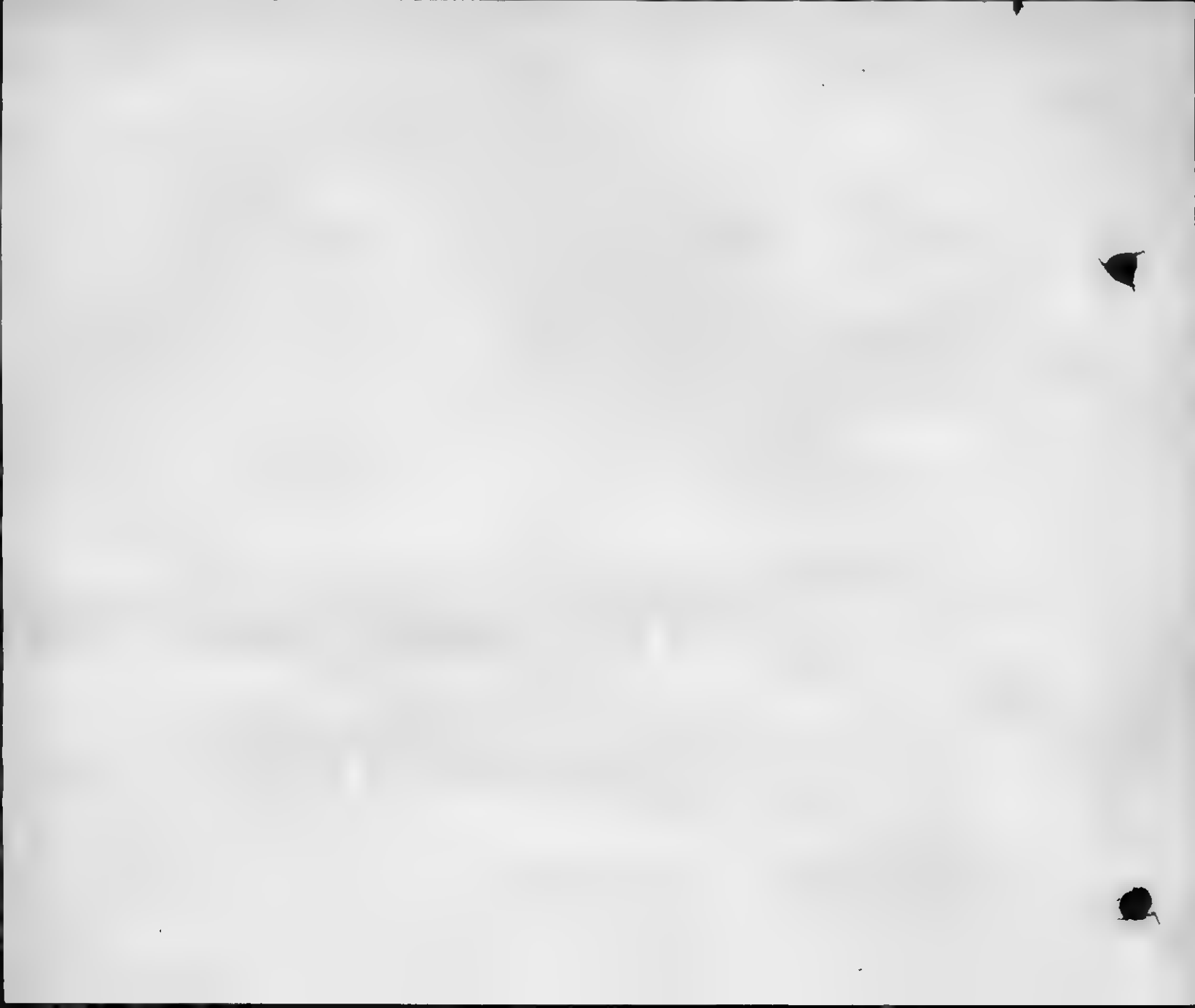
## CERTIFICATE OF DEATH

14049

14081

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MONTGOMERY</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY (In 1b) <u>1 1/2 hr.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hosp.</u> |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>d. STREET ADDRESS <u>8610 Garland Av.</u> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><u>Louis Aaron Davidoff</u>  |  | <b>4. DATE OF DEATH</b><br>Month <u>12</u> Day <u>25</u> Year <u>1961</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| <b>5. SEX</b><br><u>MALE</u>  |  | <b>6. COLOR OR RACE</b><br><u>White</u>  |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |
| <b>8. AGE</b> (In years last birthday) <u>23</u> yrs.   |  | <b>9. DATE OF BIRTH</b><br><u>MAR. 31 - 88</u>   |  | <b>10. AGE</b> (In years last birthday) <u>23</u> yrs.  |  |  |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Russia</u>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>   |  | <b>13. FATHER'S NAME</b><br><u>ISRAEL DAVIDOFF</u>  |  |  |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br><u>Liebe Lankus</u>  |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <u>NO</u>  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>028-039314</u>   |  |  |  |
| <b>17. INFORMANT</b><br><u>Hospital Records</u>   |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u><br>(b) <u>Coronary artery disease</u><br>(c) <u>Coronary arteriosclerosis</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 hours</u><br><u>5 years</u>  |  |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Hypertension and peripheral arteriosclerosis</u>   |  |  |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  |  |  |
| <b>20f. (City or town)</b>  |  | <b>20g. (County)</b>   |  | <b>20h. (State)</b>   |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June</u> <u>1958</u> <b>to</b> <u>Dec 25</u> <u>1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Dec 25</u> <u>1961</u> , <b>and that death occurred at</b> <u>1 P.M.</u> <b>from the causes and on the date stated above.</b>     |  |  |  |   |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Saul Holtzman</u>   |  | <b>22b. DATE SIGNED</b><br><u>Dec 25 1961</u>  |  | <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Saul Holtzman</u>   |  |  |  |
| <b>22d. ADDRESS</b><br><u>1800 Eye St. NW Wash DC</u>   |  | <b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>   |  | <b>22f. ADDRESS</b>   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>BURIAL</u>   |  | <b>23b. DATE THEREOF</b><br><u>12/27/61</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>GEO. WASHINGTON</u>   |  |  |  |
| <b>23d. LOCATION</b> (City, town or county)<br><u>HYATTSVILLE, MD.</u>  |  | <b>23e. REC'D BY REGISTRAR</b>   |  | <b>23f. REGISTRAR'S SIGNATURE</b>   |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Deeley Funeral Home</u>   |  |  |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14082

14050

|   |                               |   |                                      |
|---|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN <u>MARYLAND</u> <u>3 weeks</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>District of Columbia</u> b. COUNTY <u>✓</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u><br>d. STREET ADDRESS <u>7019 Georgia Ave</u> |                                      |
| 3. NAME OF DECEASED (Type or print) <u>Molly Ellen Davis</u>  |                               | 4. DATE OF DEATH<br>Month <u>Dec</u> Day <u>26</u> Year <u>1961</u>   |                                      |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>Oct 16, 1871</u> |
| 9. AGE (In years last birthday) <u>90</u> yrs.  |                               | 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>10</u> Hours <u>0</u> Min <u>0</u>  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |                               | 11. BIRTHPLACE (County & State, or foreign country) <u>Tenn.</u>  |                                      |
| 13. FATHER'S NAME <u>John Webb</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Eliza Johnson</u>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>7019 Ga Ave NW</u>   |                                      |
| 17. INFORMANT <u>Mrs Louise Kaldenbach</u>  |                               | Address <u>7019 Ga Ave NW</u>   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><u>163X</u> IMMEDIATE CAUSE (a) <u>Disturbances of Rhythm &amp; Conduction to heart &amp; cystic duct</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Recurrent Hypertension</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>None</u> |                               |   |                                      |
| 19. INTERVAL BETWEEN ONSET AND DEATH <u>17</u> days   |                               |   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |   |                                      |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                               |   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>10</u> p.m. <u>12</u> 19 <u>61</u>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/26/1961</u> to <u>12-26-1961</u> , that (I) (we) last saw the deceased alive on <u>12/26/1961</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.   |                               |   |                                      |
| 22a. SIGNATURE <u>Chas H. Wolstein</u>  |                               | 22b. DATE SIGNED  |                                      |
| 22c. PHYSICIAN'S NAME (Type) <u>Chas H. Wolstein</u>  |                               | 22d. ADDRESS <u>7600 Carroll Ave Shome Park Md</u>  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE THEREOF <u>12-29-61</u>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>  |                               | 23d. LOCATION (City, town or county) (State) <u>Smithland Md</u>  |                                      |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>   |                               | 25a. REC'D BY REGISTRAR <u>JAN 2 '62</u>  |                                      |
| ADDRESS <u>4812 Ga Ave NW</u>   |                               | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>  |                                      |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

Item 18 Film 305  
1-11-62 ams

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

14083 14051

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Restmor

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE md. b. COUNTY Montgomery  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda  
d. STREET ADDRESS 8820 River Rd.

3. NAME OF DECEASED (Type or print)  
First Middle Last  
James EDWARD DAY

4. DATE OF DEATH  
Month Day Year  
12 3 1961

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 1/30/1887 9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardening 10b. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (County & State, or foreign country) USA.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Samuel Day 14. MOTHER'S MAIDEN NAME Rachel Kickett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 578-10-2703 17. INFORMANT Elsie Day-Wife-same 2d Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 053.4 DUE TO Undetermined  
CONTRIBUTING CAUSE (b) Mediastatin carcinoma DUE TO Undetermined  
CAUSE LAST (c) Mediastatin carcinoma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

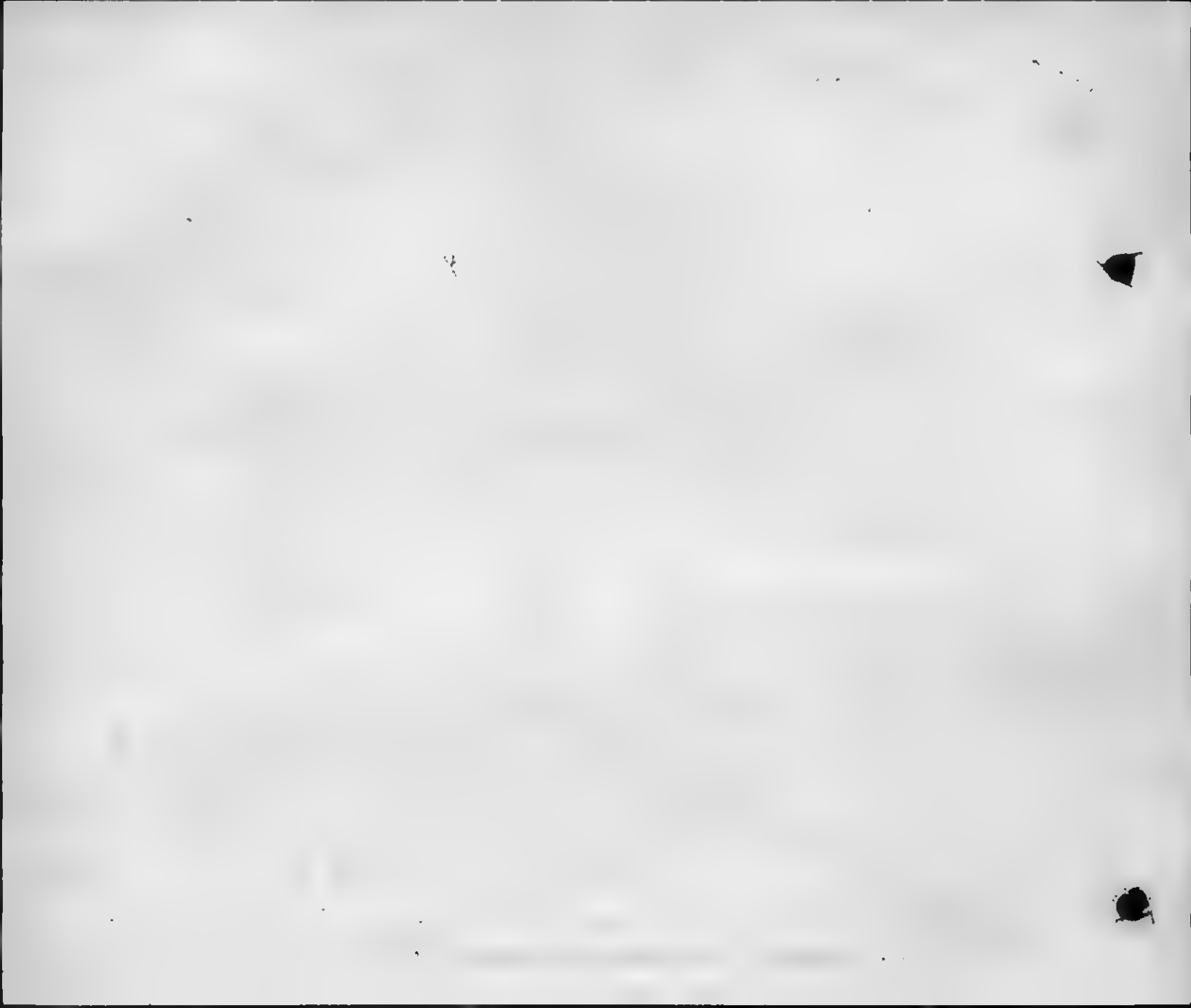
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 12/3 1961 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, off campus, etc.) 1835 Eye St NW - Wash 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/24 1961 to 12/3 1961, that (I) (we) last saw the deceased alive on 12/3 1961, and that death occurred at 5:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE Alvin I. Kay M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 12/3/61  
22c. PHYSICIAN'S NAME (Type) Alvin I. Kay MD 22d. ADDRESS 1835 Eye St NW - Wash

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 12/6/61 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem. 23d. LOCATION (City, town or county) (State) Silver Spring, Md.

24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland 25a. REC'D BY REGISTRAR DEC 6 '61 25b. REGISTRAR'S SIGNATURE Robert S. Kline



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14084

Items 8 & 9 Film G303 12/20/61 iwk

14052

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN IB

One week

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium and Hospital

3. NAME OF DECEASED (Type or print)

Johanna

First

Middle

(NMN) DeCarlo

### 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Md.

b. COUNTY

Montgomery

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

9301 Ocala St.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

4. DATE OF DEATH

Month

Day

Year

Dec

8

1961

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

June 21 1886

9. AGE (In last birthday)

75 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Connecticut

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Vincent Jamele

14. MOTHER'S MAIDEN NAME

Mary XXXXXXXXXX Jackarosa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mr. Nicholas C. DeCarlo

19408 Pine Oak Drive, Silver Spring, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

Myocardial infarction, acute anterior

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 15, 1961, to Dec. 8, 1961, that (I) saw the deceased alive on Dec. 8, 1961, and that death occurred at 1:30 PM, from the causes and on the date stated above.

22a. SIGNATURE

Raymond Bradshaw

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

12/8/61

22c. PHYSICIAN'S NAME (Type)

Raymond Bradshaw

22d. ADDRESS

345 University Blvd W Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

12/12/61

23c. NAME OF CEMETERY OR CREMATORY

GATE OF HEAVEN CEMETERY

23d. LOCATION (City, town or county)

MONTGOMERY, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE

Raymond E. Pumphrey

ADDRESS

8434 GEORGIA AVENUE

25a. REC'D BY REGISTRAR

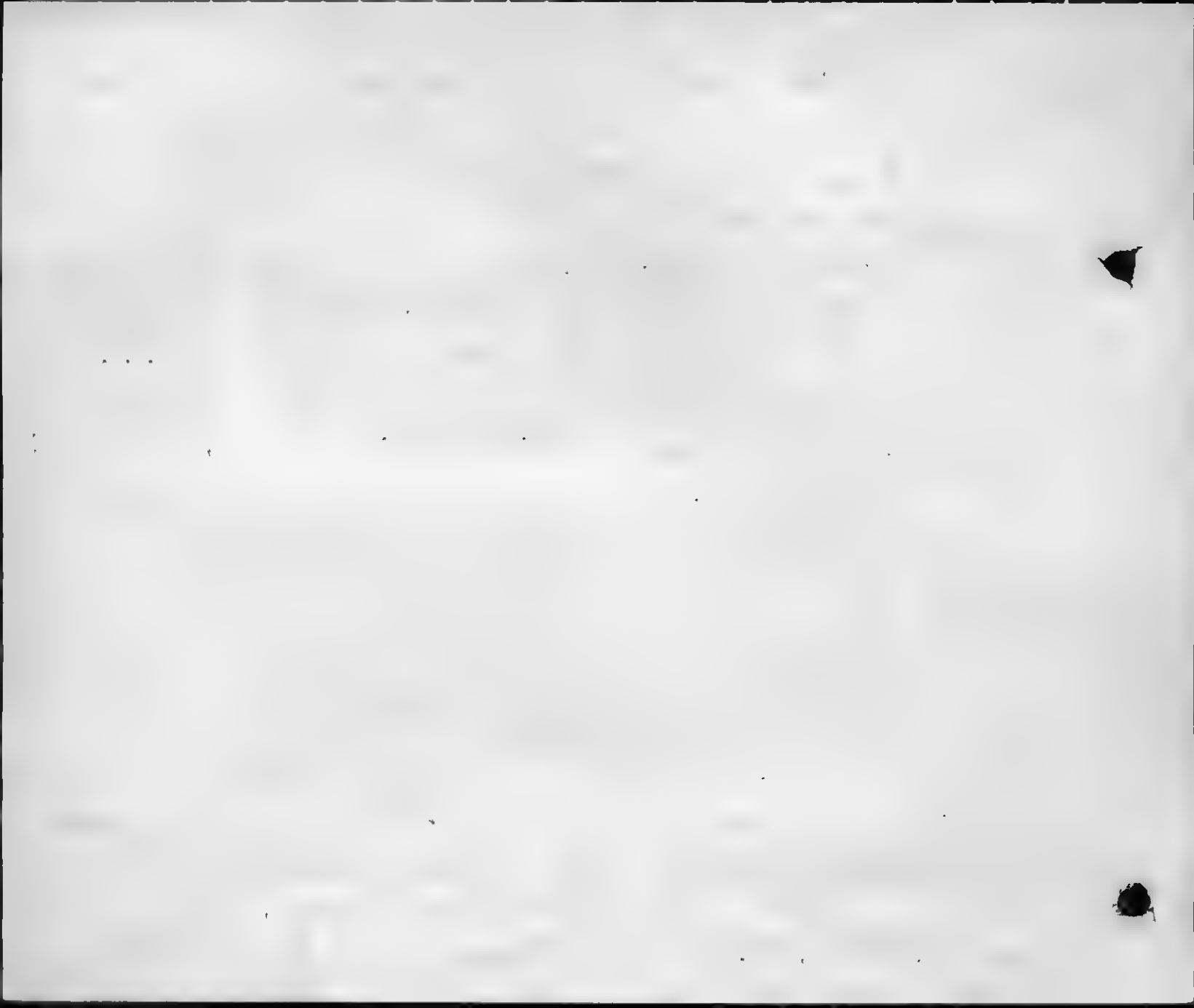
DATE DEC 13 '61

25b. REGISTRAR'S SIGNATURE

C. W. S. Pumphrey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/60

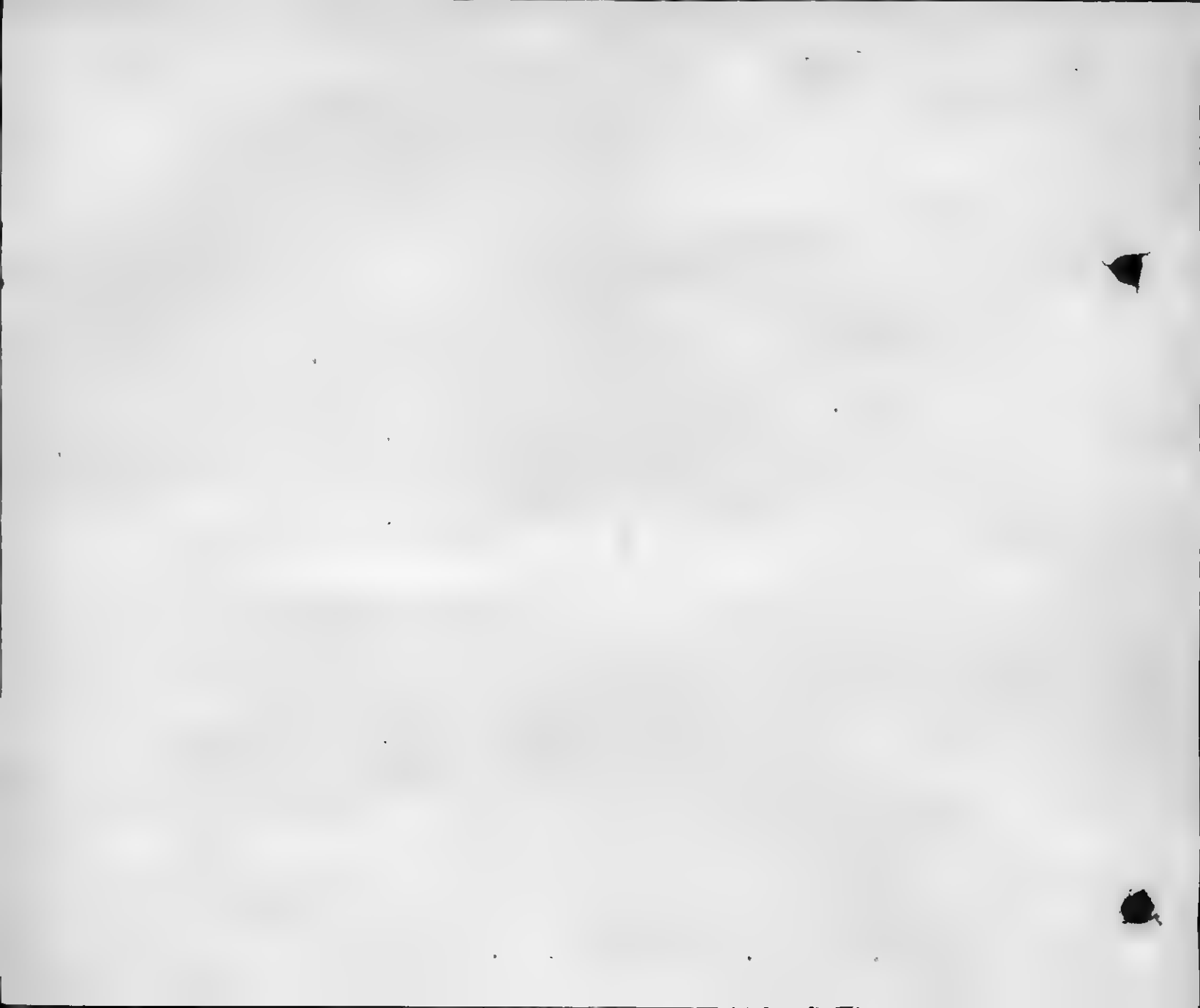




THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                  |  |   |  |   |  |  |  |   |  |
|---|--|----------------------------------|--|---|--|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                  |  |   |  |   |  |  |  |   |  |
| 14085   |  |                                  |  |   |  | 14053   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montg</u> <u>MARYLAND</u>   |  |                                  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Gaithersburg</u>   |  |                                  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>17 Gaithersburg</u>                                |  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>18 Maryland Ave</u>  |  |                                  |  |   |  | d. STREET ADDRESS<br><u>18 Maryland Ave</u>   |  |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Herbert Laurence Diamond</u>   |  |                                  |  |   |  | 4. DATE OF DEATH<br>Month <u>Dec</u> Day <u>5th</u> Year <u>1961</u>  |  |  |  |   |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Aug 15-1894</u>  |  | 9. AGE (In years last birthday)<br><u>77</u> yrs. <u>3</u> Months <u>20</u> Days |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>   |  |                                  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Montg. Co. Md.</u>     |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |  |
| 13. FATHER'S NAME<br><u>John B. Diamond</u>   |  |                                  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Grace Hanney</u>   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)  |  |                                  |  |   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><u>John S. Diamond 3rd. Rockville.</u>                          |  | Address                                       |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Left Ventricular Heart Failure</u><br>4-10 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u><br>(c) <u>Heart</u><br>causing the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><u>6 hours</u>  |  |                                  |  |   |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                  |  |   |  |   |  |  |  |   |  |
| MEDICAL CERTIFICATION<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br>21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1961</u> to <u>Dec. 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>12-5-1961</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.<br>22a. SIGNATURE <u>Jack Schumacher</u> M.D.<br>22b. PHYSICIAN'S NAME (Type)<br>22c. DATE<br><u>12-6-61</u><br>22d. ADDRESS<br>22e. REC'D BY REGISTRAR<br>22f. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u> |  |                                  |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |                                  |  | 23b. DATE THEREOF<br><u>12-7-61</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Rose</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Gaithersburg. Rural</u>       |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Ernest C. Gartner. Gaithersburg. Md.</u>   |  |                                  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 7 '61</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>                             |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

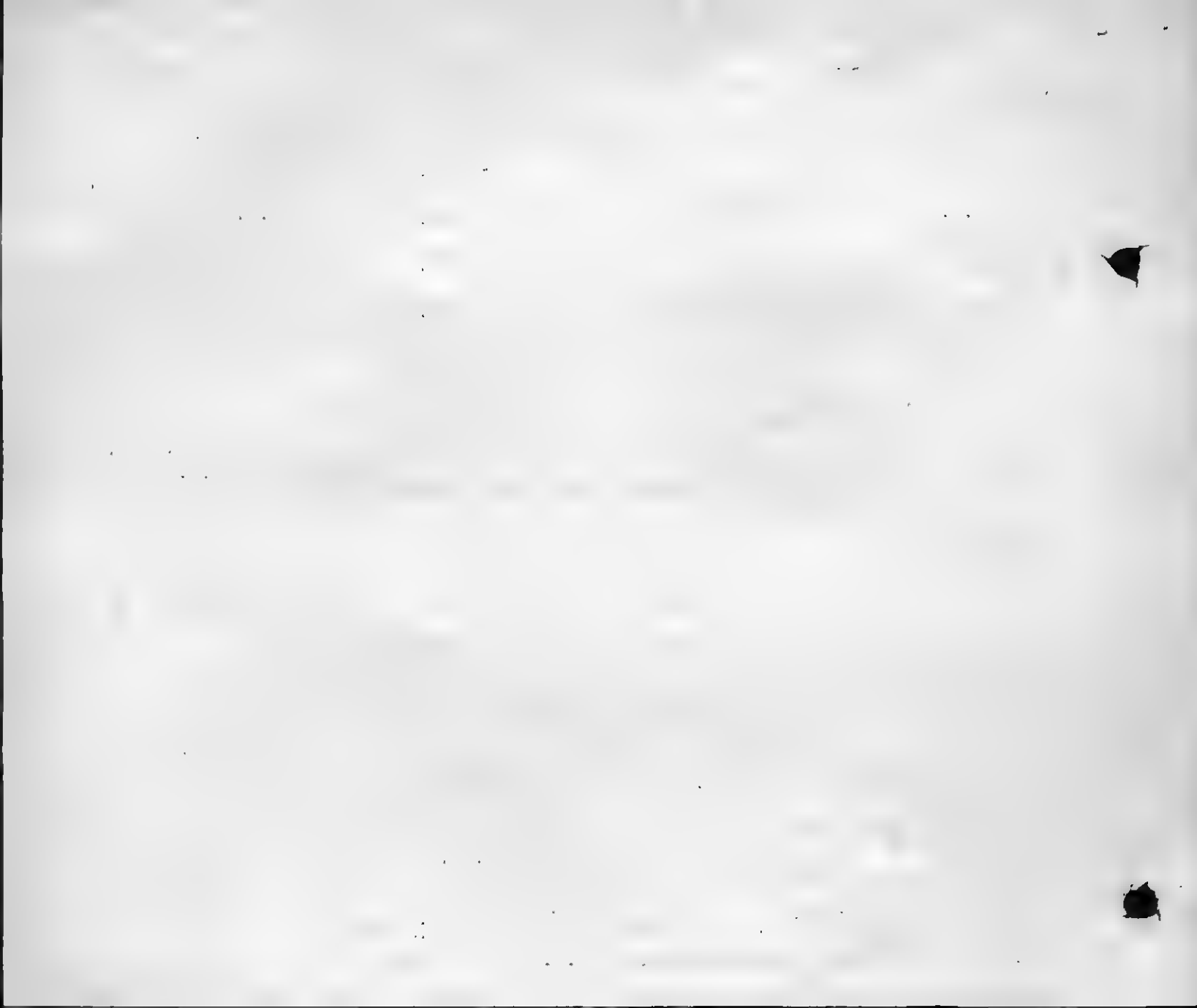
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14086

14054

|   |   |   |   |
|---|---|---|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u><br>c. LENGTH OF STAY IN lb <u>35 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. Naval Hospital Bethesda, Md.</u> |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>District of Columbia</u><br>b. COUNTY <u>District of Columbia</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u><br>d. STREET ADDRESS <u>1107 Alabama Ave., S.E.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) First <u>Lida</u> Middle <u>May</u> Last <u>DICE</u>  |   | <b>4. DATE OF DEATH</b><br>Month <u>December</u> Day <u>5</u> th Year <u>1961</u>   |   |
| <b>5. SEX</b><br><u>Female</u>  | <b>6. COLOR OR RACE</b><br><u>Caucasian</u> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br><u>2 February 1886</u> |
| <b>9. AGE</b> (In years last birthday) <u>75</u> yrs  |   | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |   |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>District of Columbia</u>  |   | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>  |   |
| <b>13. FATHER'S NAME</b><br><u>SHERWOOD, Joseph</u>   |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>FAIRALL, Sarah</u>  |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>   |   | <b>16. SOCIAL SECURITY NO.</b> <u>UNKNOWN</u>   |   |
| <b>17. ADDRESS</b><br><u>James D. DICE 1107 Alabama Ave., S.E. Washington, D.C.</u>   |   | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>(a) IMMEDIATE CAUSE (e) <u>metastatic carcinoma of breast.</u><br>(b) <u>DOX</u> DUE TO<br>(c) <u>DOX</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e) <u>INTERVAL BETWEEN ONSET AND DEATH</u> |   |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |   |
| <b>20c. TIME OF INJURY</b> Month <u>19</u> Day <u>19</u> Year <u>1961</u><br>Hour <u>5</u> a.m. <u>15</u> p.m.  |   | <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |   |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |   | <b>20f. (City or town)</b> (County) (State)   |   |
| <b>21. I certify that</b> (If this hospital) attended the deceased from <u>24 October 1961</u> to <u>5 December 1961</u> , that (I) (we) last saw the deceased alive on <u>5 December 1961</u> , and that death occurred at <u>5:15 AM</u> from the causes and on the date stated above.                                    |   |   |   |
| <b>22a. SIGNATURE</b><br><u>Benjamin J. Gilson</u>  |   | <b>22b. DATE SIGNED</b><br><u>December 5, 1961</u>  |   |
| <b>22c. PHYSICIAN'S NAME</b> (Type) <u>BENJAMIN J. GILSON LT MC USN</u>   |   | <b>22d. ADDRESS</b><br><u>U. S. Naval Hospital, Bethesda, Md.</u>   |   |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>  |   | <b>23b. DATE THEREOF</b><br><u>12-8-61</u>  |   |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Arlington National Cemetery</u>   |   | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Arlington, Virginia</u>   |   |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Simmons Funeral Home</u>  |   | <b>25a. REC'D BY REGISTRAR</b><br><u>DEC 7 '61</u>  |   |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Simmons Funeral Home Good Hope Rd., S.E.</u>  |   | <b>25c. REGISTRAR'S SIGNATURE</b><br><u>Wm. S. Evans</u>  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)  
 74  
 1

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

14087 Items 2 & 14 from birth cert 14055

1. PLACE OF DEATH  
 a. COUNTY Montgomery MARYLAND  
 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda  
 c. LENGTH OF STAY IN b. 34  
 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)  
 a. STATE Maryland  
 b. COUNTY Montgomery  
 c. CITY OR TOWN (If outside corporate limits) Wheaton  
 d. STREET ADDRESS 11935 Andrews Street  
 e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)  
 First Boy Middle Dipietro Last 11-30-61

4. DATE OF DEATH  
 Month 12 Day 1 Year 1961

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. AGE (In years last birthday) 12 yrs. IF UNDER 1 YEAR Months 1 Days 16 Hours 60 Min. 60

9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Montgomery MD 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Nicholas Di Pietro 14. MOTHER'S MAIDEN NAME Emma A. Dinnis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 17. INFORMANT Address

18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).]  
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) 760.0 DUE TO INTRACranial hemorrhage  
 Conditions, if any, which gave rise to immediate cause (b) Laceration of Tentorium Cerebelli  
 (e), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

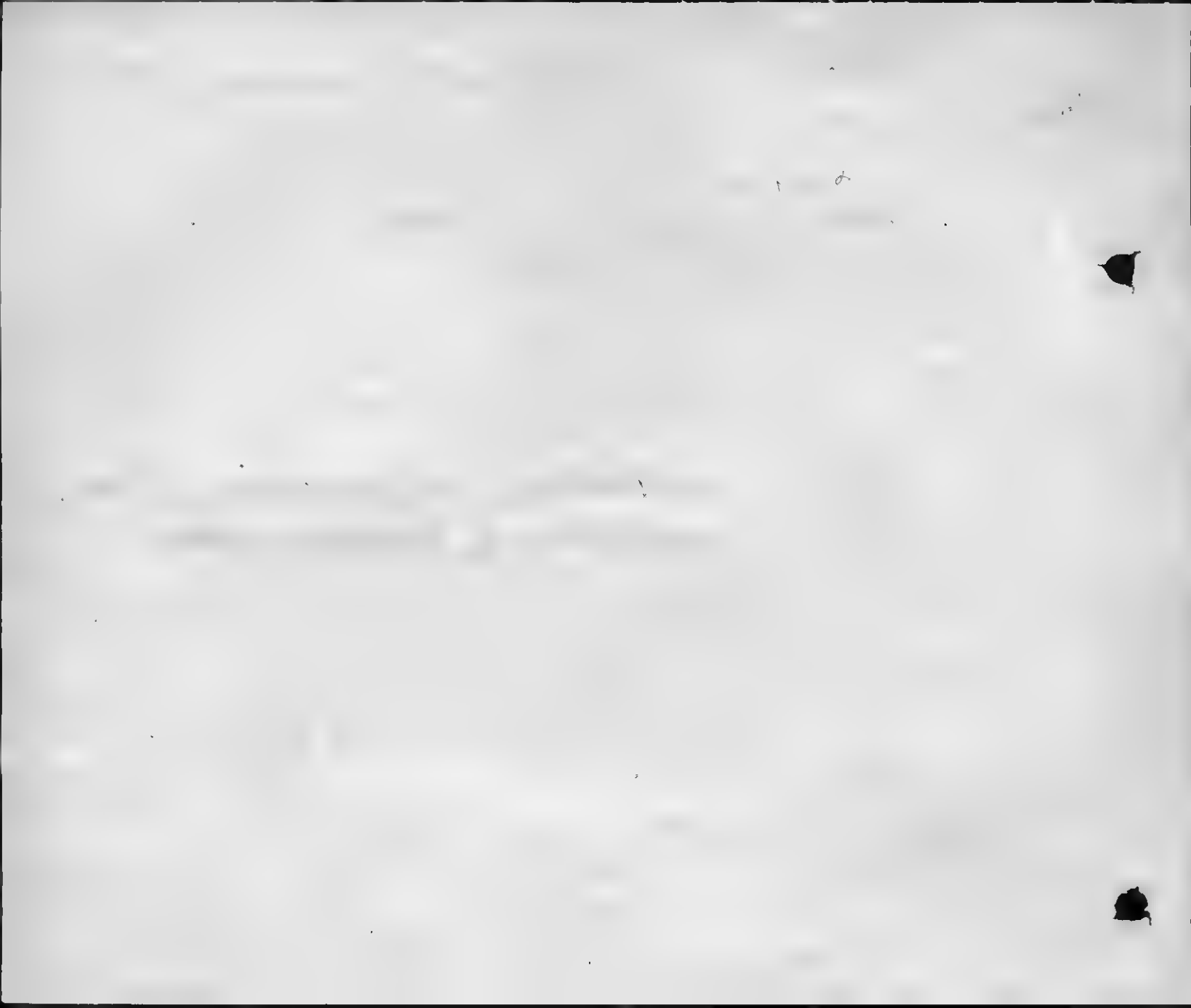
21. I certify that (I) (this hospital) attended the deceased from NOV 30, 1961 to Dec 1, 1961, that (I) (we) last saw the deceased alive on Dec 1, 1961, and that death occurred at 11:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE James Pearlman M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION 23b. DATE THEREOF 12-2-61 23c. NAME OF CEMETERY OR CREMATORY SUBURBAN HOSPITAL 23d. LOCATION (City, town or county) (State) BETHESDA, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE AMELIA C. CARTER, Admin. - SUBURBAN HOSP. BETHESDA, MD. ADDRESS 25a. REC'D BY REGISTRAR DEC 5 '61 25b. REGISTRAR'S SIGNATURE Amelia C. Carter



FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

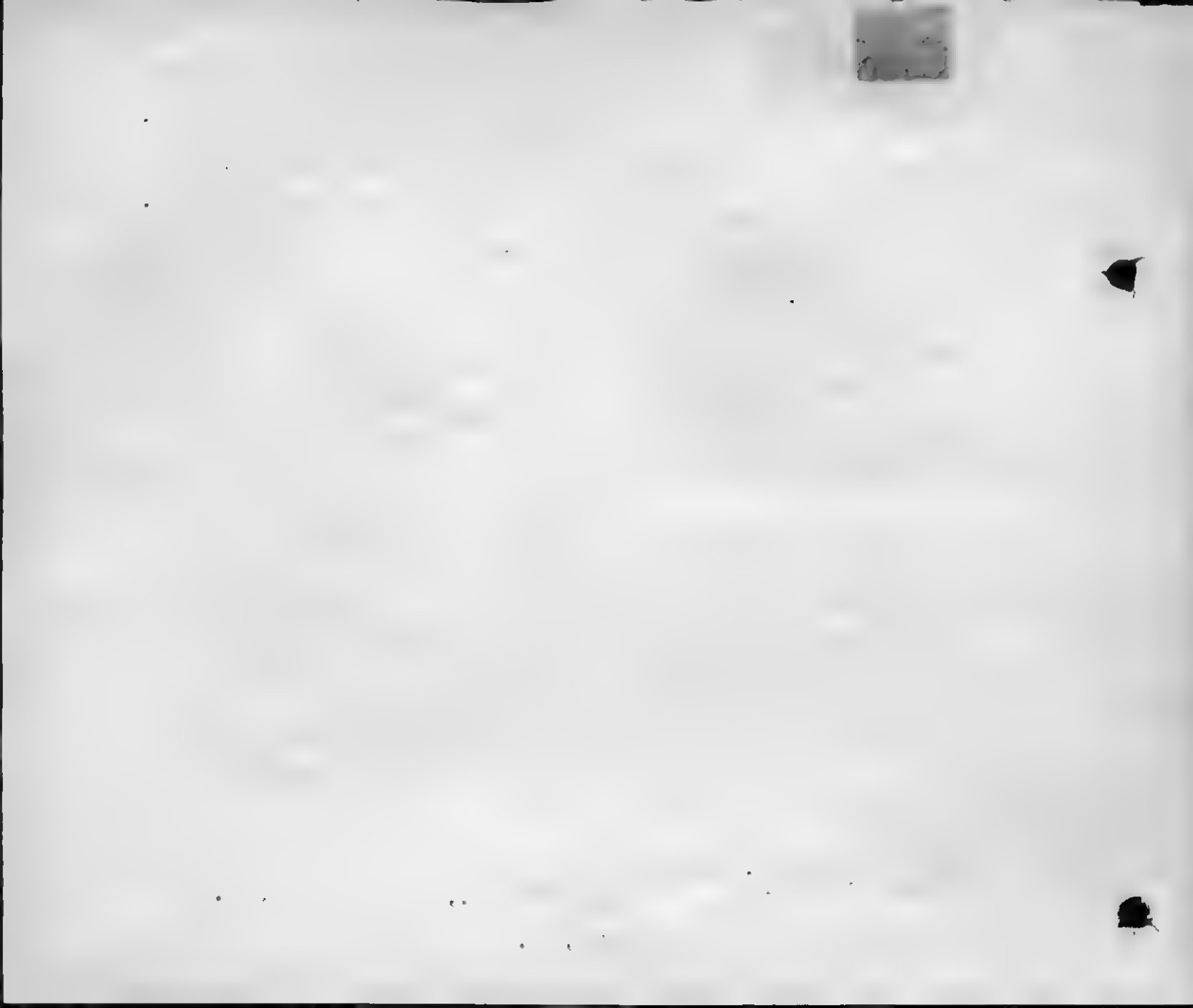
VS. A15ME  
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b> |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Olney</b>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring (Rural)</b>                             |  |
| c. LENGTH OF STAY IN 1b <b>DOA</b>  |  | d. STREET ADDRESS <b>rear of 14615 Good Hope Rd.</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) <b>William E Dorsey</b>   |  | 4. DATE OF DEATH <b>12 8 1961</b>   |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>Col.</b>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>   |  | 8. DATE OF BIRTH <b>5-6-1912</b>  |  |
| 9. AGE (In years last birthday) <b>49</b> yrs.  |  | 10. IF UNDER 1 YEAR Months Days   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country) <b>Ind</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |
| 13. FATHER'S NAME <b>Garfield Dorsey</b>  |  | 14. MOTHER'S M.A.DEN NAME <b>Unknown</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT   |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br>DUE TO (b) <b>Chronic pulmonary Interstitial</b><br>DUE TO (c) <b>Pneumorectomy left lung in distant part</b>  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of Item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year 19 <b>12/14/61</b>   |  |   |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |   |  |
| 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  |
| DATE SIGNED <b>12/8/61</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  |   |  |
| 22b. NAME OF CEMETERY OR CREMATORY <b>Arlington National., Arlington, Va.</b>   |  |   |  |
| 22c. LOCATION (City, town, or country) (State)  |  |   |  |
| 23. FUNERAL DIRECTOR <b>Robert L. Snowden</b> ADDRESS <b>Rockville, Md.</b>   |  |   |  |
| 24a. REC'D BY REGISTRAR <b>DEC 14 '61</b>   |  |   |  |
| 24b. REGISTRAR'S SIGNATURE <b>Robert L. Snowden</b>   |  |   |  |

MEDICAL CERTIFICATION





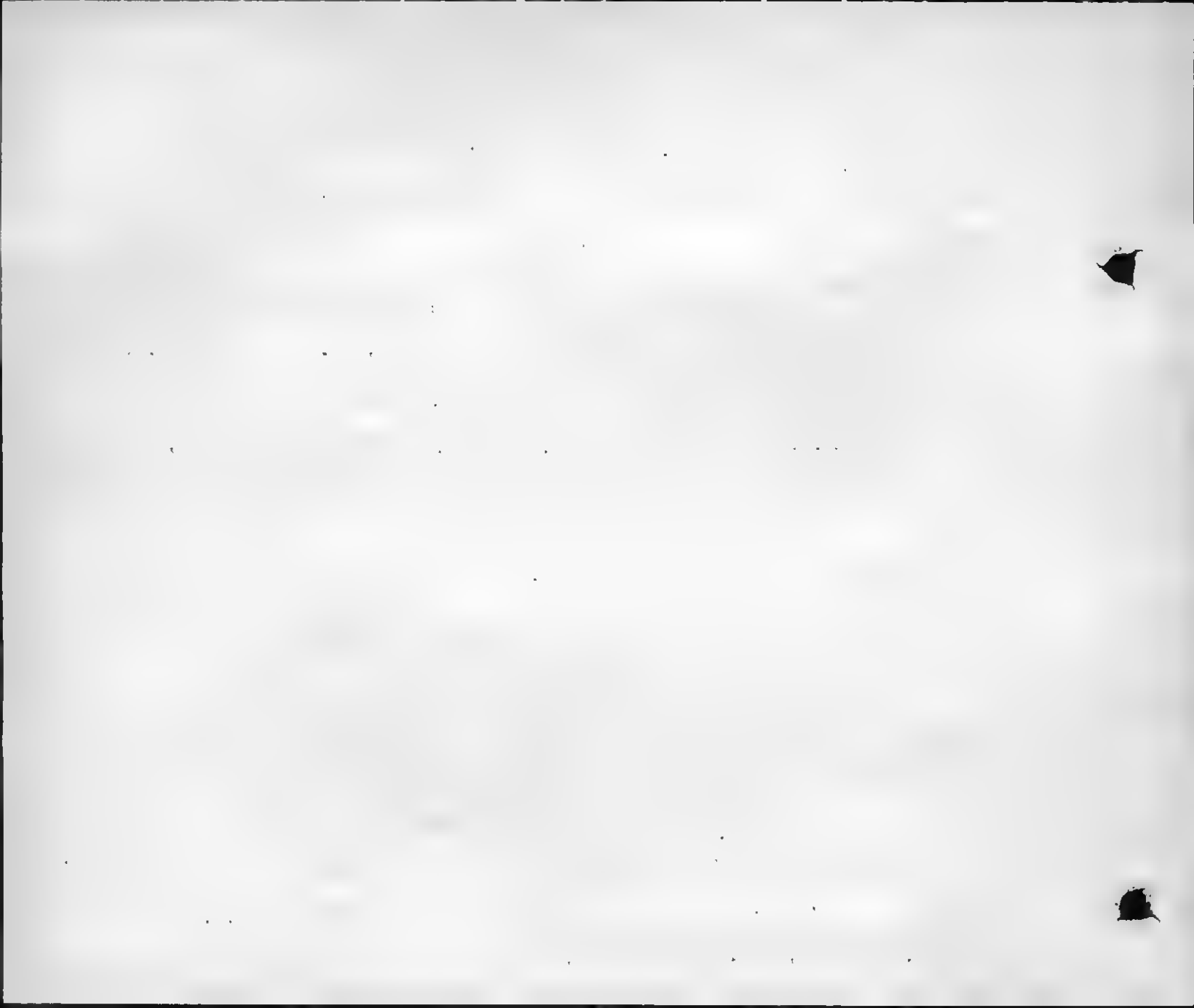
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

14089

**CERTIFICATE OF DEATH**

14057

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington, Md.</b>  |   | c. LENGTH OF STAY IN 1b<br><b>9 months</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Kensington Gardens Sanitarium</b>   |   | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring,</b>   |   |
| f. STREET ADDRESS<br><b>8407 Hartford Avenue</b>  |   | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Catherine</b> First <b>Nelms</b> Middle <b>Downing</b> Last   |   | 4. DATE OF DEATH<br><b>Dec. 11 1961</b> Month Day Year  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 6, 1870</b>   |
| 9. AGE (In years last birthday) yrs.<br><b>91</b>   |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS.<br>Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOMEMAKER</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>HEATHSVILLE, VA.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Gustavus Betts</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Basye</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>NO</b>  |   | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |   |
| 17. INFORMANT<br><b>MR. OSCAR B. DOWNING</b>  |   | Address<br><b>8407 Hartford Avenue Silver Spring, Maryland</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cerebral infarction</b><br>DUE TO <b>491X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>MI. previous</b><br>DUE TO <b>Arteriosclerosis</b><br>(c) <b>Arteriosclerosis + atherosclerosis</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Arteriosclerosis + atherosclerosis</b>  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br>19  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12-11-61</b> to <b>12-11-61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12-11-61</b> , and that death occurred at <b>11 A.</b> from the causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><b>Marion Widler</b>  |   | 22b. DATE SIGNED<br><b>12/11/61</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>MARION WIDLER</b>  |   | 22d. ADDRESS<br><b>8218 Wisconsin Ave Silver Spring, Md.</b>  |   |
| 23a. BURIAL CREMATION REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>12/14/61</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ROCK CREEK CEMETERY</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>WASHINGTON D.C.</b>                           |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Warner E. Pumphrey</b>   |   | 25a. REC'D BY REGISTRAR<br><b>15 61</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>12 11 61</b>   |   |   |   |



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                |  |   |  |  |  |   |  |  |  |
|--|--|--------------------------------|--|---|--|--|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                |  |   |  |  |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |                                |  |   |  |  |  |   |  |  |  |
| 14058  |  |                                |  |   |  |  |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt #1 Gaithersburg, Md</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  |                                |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt #1 Gaithersburg, Md</u><br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>Marion Frances Duvall</u>  |  |                                |  | 4. DATE OF DEATH<br>Month Day Year<br><u>December 5, 1961</u>   |  |  |  |   |  |  |  |
| 5. SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>Col</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><u>May 28, 1934</u>                                |  | 9. AGE (In years last birthday)<br><u>27</u> Yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days<br><u>27</u> <u>0</u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  |                                |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |  |  | 11. BIRTHPLACE (Country & State, or foreign country)<br><u>Pennsylvania</u>                             |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>            |  |
| 13. FATHER'S NAME<br><u>Henry Moore</u>  |  |                                |  | 14. MOTHER'S MAIDEN NAME<br><u>Harriett Stewart</u>   |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  |                                |  | 16. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT Address   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Right Ovary.</u><br><u>175.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) _____<br>(a), stating the underlying cause last. DUE TO (c) _____ |  |                                |  |   |  |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |  |                                |  |   |  |  |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                |  |   |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |                                |  |   |  |  |  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |                                |  |   |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  |  |                                |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) _____ (County) _____ (State) _____  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>August 1961</u> to <u>Dec 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec 3, 1961</u> , and that death occurred at <u>3:10</u> P.M. from the causes and on the date stated above.   |  |                                |  |   |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br><u>Luciano I. Led</u> M.D.   |  |                                |  |   |  |  |  |   |  |  |  |
| 22b. DATE SIGNED   |  |                                |  |   |  |  |  |   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Luciano I. Led</u>   |  |                                |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  |                                |  | 23b. DATE THEREOF<br><u>12/10/61</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Brooke Grove.,</u>            |  | 23d. LOCATION (City, town or county) _____ (State) _____<br><u>Laytonsville, Md.</u>                    |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert L. Snowden</u>   |  |                                |  | ADDRESS<br><u>Rockville, Md.</u>  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 11 '61</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Luciano I. Led</u>      |  |



14091

## CERTIFICATE OF DEATH

Reg. Dist. No. 14059

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>               |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town)<br><u>TAKOMA PARK</u>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town)<br><u>TAKOMA PARK</u>   |  |   |   |
| c. LENGTH OF STAY in 1b<br><u>3 DAYS</u>  |  |   |  | d. STREET ADDRESS<br><u>8011 CARROLL ST</u>   |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>WASH. SANT. Hosp.</u>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>FLORENCE</u> Middle <u>C</u> Last <u>ELLIOTT</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>Dec</u> Day <u>25</u> Year <u>1961</u>   |  |   |   |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Dec. 3, 1889</u>                                 |   |
| 9. AGE (In years last birthday)<br><u>72</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>                         |  | IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>At Home</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Wash DC</u>             |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |   |  |   |  |   |   |
| 13. FATHER'S NAME<br><u>Michael Sexton</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>MCCABE</u>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No.</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>579-26-2165</u>   |  | 17. INFORMANT<br><u>Ray Elliott</u> Address <u>9707 HERMAN DR SS MD</u> |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]   |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>  |  |   |  |   |  |   | <u>60 hrs</u>   |
| 42011 DUE TO  |  |   |  |   |  |   |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |  |   |  |   |   |
| (b) <u>Senile Arteriosclerosis</u>  |  |   |  |   |  |   | <u>10 years</u>   |
| (c) <u>  </u>   |  |   |  |   |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. 19 <u>  </u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                    |   |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>51</u> , to <u>25 Dec</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>25 Dec</u> , 19 <u>61</u> , and that death occurred at <u>6:30 P</u> . M, from the causes and on the date stated above. |  |   |  |   |  |   |   |
| ADDRESS (Street, city or town, state)   |  |   |  | DATE SIGNED   |  |   |   |
| ACTUAL SIGNATURE <u>M.B. Queen</u> M.D. <u>7112 Willow Ave</u>  |  |   |  | <u>25 Dec 1961</u>  |  |   |   |
| PHYSICIAN'S NAME (Type) <u>M.B. Queen M.D.</u>  |  |   |  | <u>Takoma Park MD</u>   |  |   |   |
| 22a. BURIAL CREMAT. OR REMOVAL (Specify)  |  | 22b. DATE THEREOF   |  | 22c. NAME OF CEMETERY OR CREMATORY  |  | 22d. LOCATION (City, town, or county) (State)                           |   |
| <u>Removal</u>  |  | <u>12/28/61</u>   |  | <u>Cedar Hill</u>   |  | <u>Sutland MD</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>W.W. Taltrow</u>   |  |   |  | ADDRESS<br><u>360314 14th NW</u>  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 27 '61</u>                       |   |
|   |  |   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>S. K. K...</u>                         |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |  |  |  |  |
| 14092 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14060  |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b><br>b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>WHEATON</b><br>c. LENGTH OF STAY IN 1b <b>1/31/61</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WHEATON NURSING HOME</b>   |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <b>PENNA.</b><br>b. COUNTY<br>c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>PLAINS</b><br>d. STREET ADDRESS <b>27 PERKINS ST.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>ROBERT JOSEPH ELWARD</b>  |  |  |  |  | 4. DATE OF DEATH <b>December 18 19 61</b><br>Month Day Year  |  |  |  |  |
| 5. SEX <b>MALE</b>   |  |  |  |  | 6. COLOR OR RACE <b>WHITE</b>  |  |  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 8. DATE OF BIRTH <b>1898 3/5/96</b><br>Yrs. Months Days  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>   |  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>   |  |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <b>PLAINS, PA.</b>   |  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  |  |  |  |
| 13. FATHER'S NAME <b>THOMAS J. ELWARD</b>  |  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>ELIZABETH LAMB</b>   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>   |  |  |  |  | 16. SOCIAL SECURITY NO. <b>None</b>  |  |  |  |  |
| 17. INFORMANT <b>Thomas Elward-Brother-Bethesda, Md.</b>   |  |  |  |  | Address  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>CORONARY OCCLUSION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HISTORY OF HYPERTENSION</b><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  |  |  |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month Day Year<br>Hour a.m. p.m. <b>19</b>   |  |  |  |  |  |  |  |  |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  |  |  |  |  |  |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |
| ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>12-18-61</b>  |  |  |  |  |  |  |  |  |  |
| Address (Street, city, town, or county)  |  |  |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |  |  |  |  |  |  |  |  |
| 22b. DATE THEREOF <b>12/19/61</b>  |  |  |  |  |  |  |  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>   |  |  |  |  |  |  |  |  |  |
| 22d. LOCATION (City, town or country) (State) <b>Hanover Township, Pa.</b>   |  |  |  |  |  |  |  |  |  |
| 23. FUNERAL DIRECTOR <b>Robert A. Pumphrey, Bethesda, Maryland</b>   |  |  |  |  |  |  |  |  |  |
| 24. REC'D BY REGISTRAR <b>DEC 21 '61</b>   |  |  |  |  |  |  |  |  |  |
| 24b. REGISTRAR'S SIGNATURE <b>Carroll D. Nunn</b>  |  |  |  |  |  |  |  |  |  |





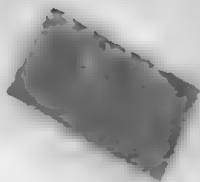
14093  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

Item 9 Film G-205 12/21/61 1wk  
 14061  
 CERTIFICATE OF DEATH

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                  | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <b>D. C.</b> b. COUNTY                                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanatorium</b>  |                                  | d. STREET ADDRESS <b>1343 KALMIA ROAD N.W.</b>   |  |
| 3 NAME OF DECEASED (Type or print) <b>Rufus P. Embrey</b>  |                                  | 4. DATE OF DEATH <b>Dec 7 1961</b>   |  |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>W</b>        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>8-29-84</b> 77 YRS                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Virginia</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>Embrey, R. J.</b>   |                                  | 14. MOTHER'S MAIDEN NAME <b>Savin, Katie</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <b>LEE ANNA EMBREY - 1343 KALMIA RD NW</b>   |                                  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE AND ARTERIOSCLEROTIC VASCULAR DISEASE</b><br>DUE TO<br>(c) <b>5 YEARS</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH <b>4 WEEKS</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21 I certify that (I) (this hospital) attended the deceased from <b>MARCH 1959</b> to <b>DECEMBER 7 1961</b> , that (I) (we) last saw the deceased alive on <b>DECEMBER 6 1961</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above.   |                                  |  |  |
| 22a. SIGNATURE <b>Robert L. Krichmar</b> M.D.  |                                  | 22b. DATE <b>DECEMBER 7 1961</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>ROBERT L. KRICHMAR M.D.</b>  |                                  | 22d. ADDRESS <b>7733 AKASKA AVENUE N.W. WASHINGTON 12 D.C.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  | 23b. DATE THEREOF <b>12-9-61</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>  | 23d. LOCATION (City, town, or county) (State) <b>BLADENSBURG, MARYLAND</b> |
| 24 FUNERAL DIRECTOR'S SIGNATURE <b>Seal Funeral Home, Inc.</b>   |                                  | 25a. REC'D BY REGISTRAR <b>013 '61</b> DATE  |  |
| ADDRESS <b>4812 GEORGIA AVE WASHINGTON, D.C.</b>   |                                  | 25b. REGISTRAR'S SIGNATURE <b>J. L. Kenna</b>  |  |







FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, use execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your own use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

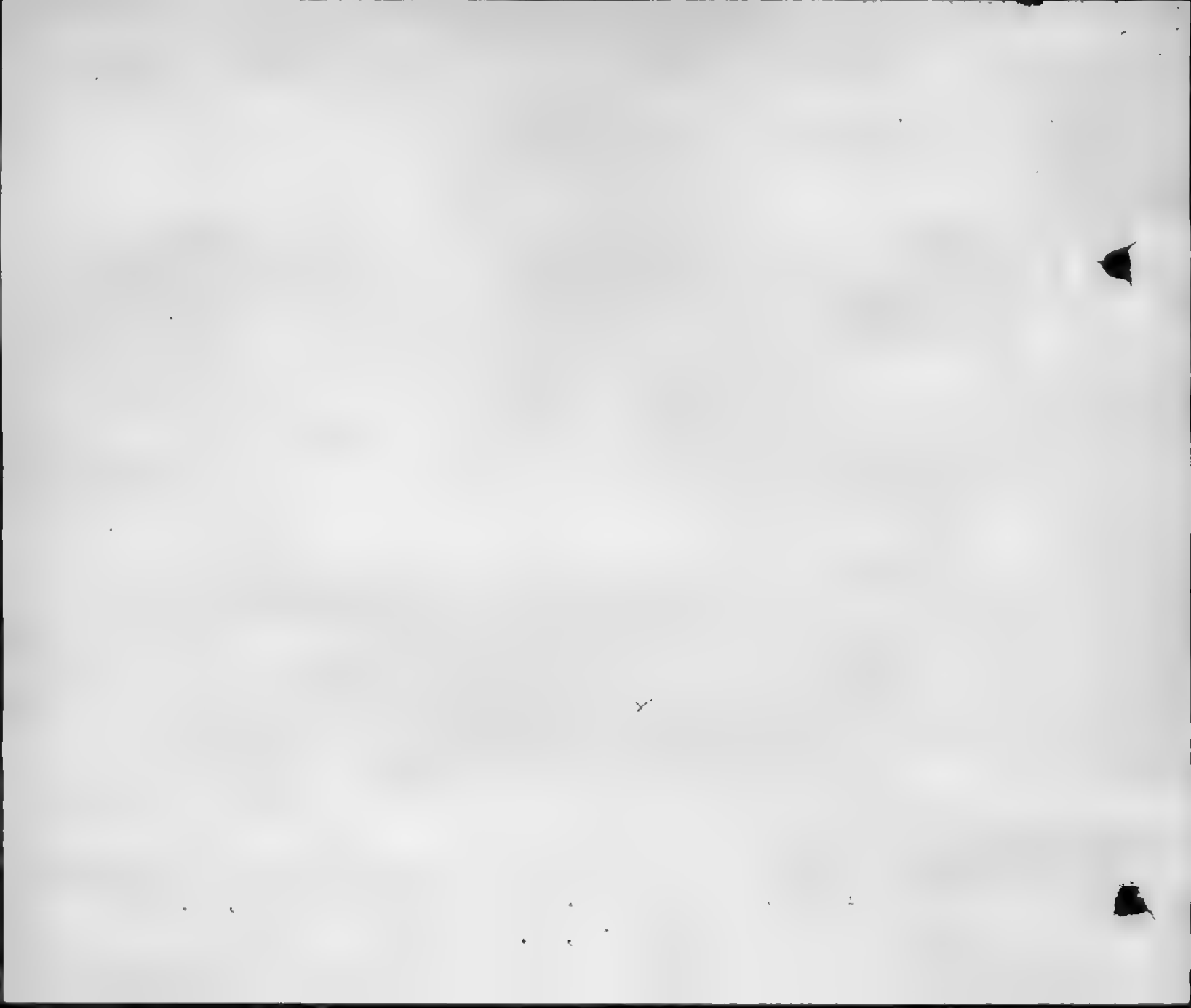
VS. A15ME  
SM 9/60

14095 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14063

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>montg</u> |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Spencerville</u>  |  | c. LENGTH OF STAY IN 1b<br><u>D.V.A.</u>  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Spencerville</u>                            |  | d. STREET ADDRESS<br><u>Brodgum Rd.</u>                                    |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Montg. Gen. Hosp.</u>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Marie Rosette Evans</u>   |  | 4. DATE OF DEATH<br>Month <u>Dec</u> Day <u>11</u> Year <u>1961</u>                                       |  | 5. SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>col</u>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>  |  | 8. DATE OF BIRTH<br><u>9-8-61</u>   |  | 9. AGE (in years last birthday)<br><u>0</u> yrs. <u>3</u> mos. <u>3</u> days   |  | 10. IF UNDER 1 YEAR<br>Months <u>3</u> Days <u>3</u>                       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                              |  |
| 13. FATHER'S NAME<br><u>James Evans</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Clara Jackson</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give year or dates of service)   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><u>Clara Evans (mother)</u>   |  | Address <u>Stim 2</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br><u>475X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u><br>DUE TO (c) <u>Grand collapsed in bed</u>  |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                       |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><u>Frank J. Broschant</u>  |  | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DATE SIGNED<br><u>12-11-61</u>   |  |  |  |
| EXAMINER'S NAME (Type)<br><u>FRANK J. Broschant</u>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | Address (Street, city, town, or county)<br><u>Spencerville, Md.</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>12/13/61</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Round Oak.</u>  |  | 22d. LOCATION (City, town, or country) (State)<br><u>Spencerville, Md.</u> |  |
| 23. FUNERAL DIRECTOR<br><u>Robert L. Snowden</u>   |  |   |  | ADDRESS<br><u>Rockville, Md.</u>   |  | 24a. REC'D BY REGISTRAR<br><u>DEC 14 '61</u>                               |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>12-11-61</u>  |  |  |  |

MEDICAL CERTIFICATION



1  
M

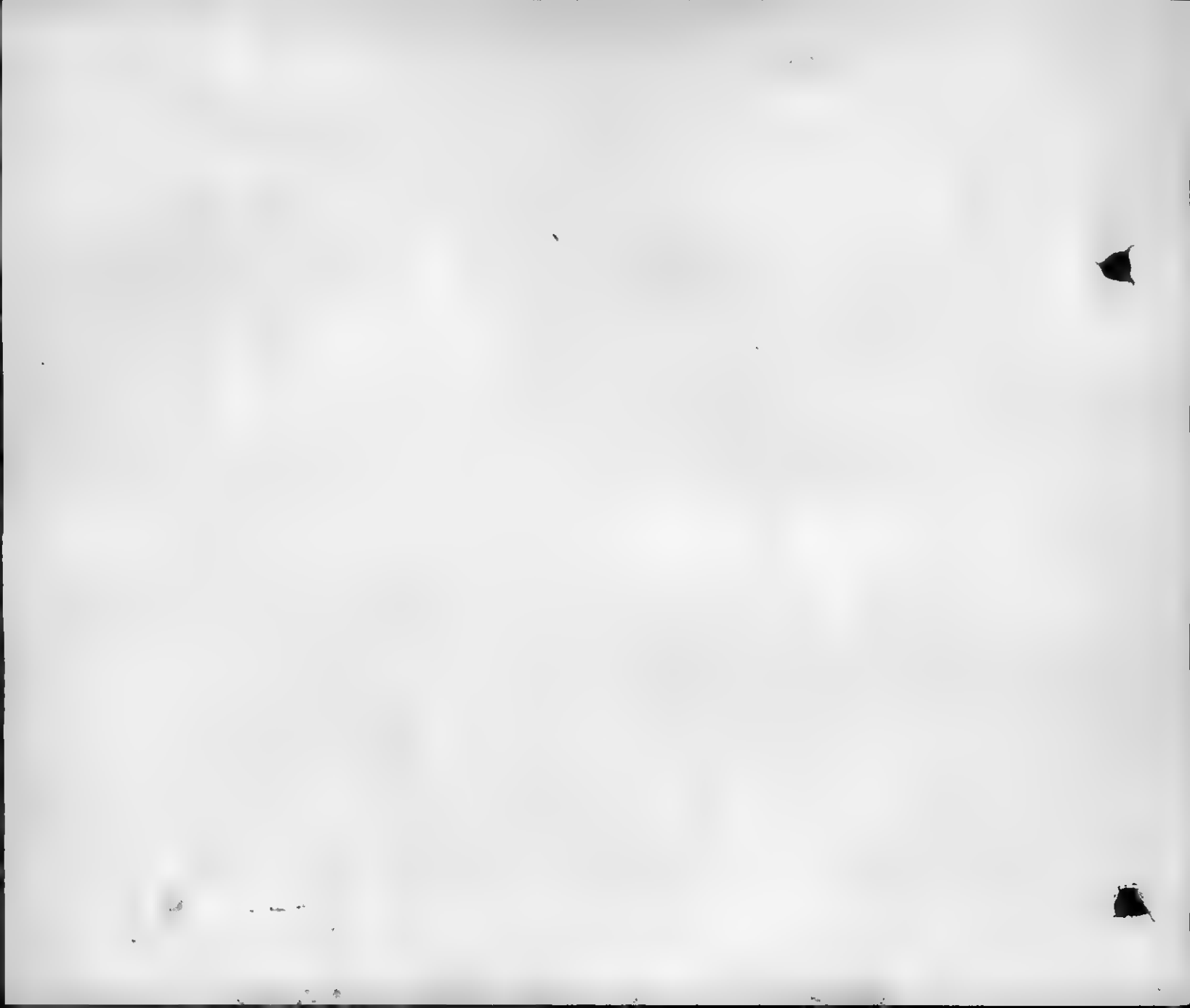
**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14096

14064

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY in ib <u>3 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before adm ssion)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>8112 New Hampshire Ave</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <u>Henriche EASTON</u><br>First Middle Last<br>4. DATE OF DEATH <u>12-18-1961</u><br>Month Day Year  |  | 5. SEX <u>Female</u><br>6. COLOR OR RACE <u>White</u><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH <u>10-2-85</u><br>Month Day Year   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u><br>11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u><br>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  | 13. FATHER'S NAME <u>James L. Easton</u><br>14. MOTHER'S MAIDEN NAME <u>Mary E Anderson</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u><br>16. SOCIAL SECURITY NO. <u>unknown</u><br>17. INFORMANT <u>Brother. (Mr. Wm H. Easton)</u><br>Address <u>Same</u>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Thrombosis superior mesenteric artery</u><br>4-50.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>General arteriosclerosis severe</u><br>(c), stating the underlying cause last. DUE TO <u>4 years</u>   |  |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19<br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/18</u> to <u>12/18</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/18</u> , 19 <u>61</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.<br>22. SIGNATURE <u>Hugh Drey</u><br>22c. PHYSICIAN'S NAME (Type) <u>Hugh Drey</u>  |  | 22b. DATE SIGNED<br>22d. ADDRESS <u>7105 Riggs Rd Lewisdale P.O. Md.</u><br>22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u><br>23b. DATE THEREOF <u>12-22-61</u><br>23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u><br>23d. LOCATION (City, town or county) (State) <u>Wash. D.C.</u>  |  | 24. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers Jr.</u><br>24a. ADDRESS <u>3655 Sa Ave SE Sfga Md.</u><br>24b. DATE <u>DEC 27 '61</u><br>24c. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>   |  |

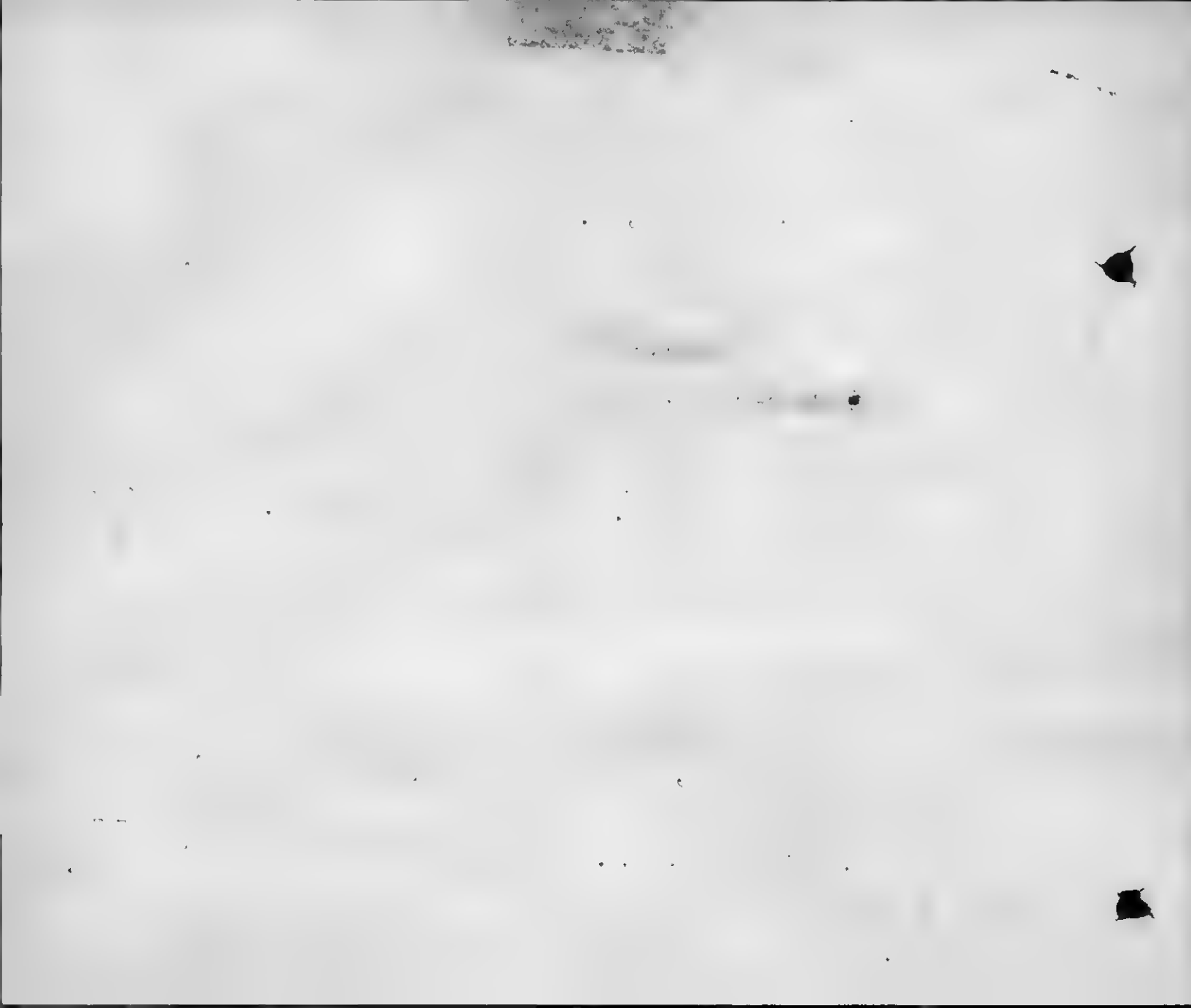




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br><del>xxxx</del> Country: <b>Tunisia</b><br>b. COUNTY  |  |
| b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |  | c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)<br><b>Tunis</b>  |  |
| c. LENGTH OF STAY IN b.<br><b>57 Days</b>   |  | d. STREET ADDRESS<br><b>No Street Address</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>The Clinical Center, Bethesda 14, Md.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Ibrahim</b>  |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>6</b> Year <b>1961</b>  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Negro</b>   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>July 20, 1925</b>   |  |
| 9. AGE (In years last birthday)<br><b>36</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>10</b> Hours <b>10</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Physician</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Medical</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>West Indies</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Algeria</b>   |  |
| 13. FATHER'S NAME<br><b>Casimir Fanon</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Eleanora Medlice</b>  |  |
| 15. WAS DECEASED EVER IN U.S. AND FOR HOW LONG? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO. <b>None</b>  |  |
| 17. INFORMANT<br><b>The Medical Records</b>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia with Pulmonary Congestion Bilateral. Pleural Effusion, Bilateral.</b><br>DUE TO (b) <b>Acute Myelogenous Leukemia</b><br>DUE TO (c) <b>10 Weeks</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>2 days</b>  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>19</b> e.m.<br>p.m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>October 10, 1961</b> to <b>December 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>December 6, 1961</b> , and that death occurred <b>3:00pm</b> from the causes and on the date stated above. |  |  |  |
| 22a. SIGNATURE<br><b>J. David Heywood</b> M.D.  |  | 22b. DATE SIGNED<br><b>12-7-61</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>J. David Heywood, M.D.</b>   |  | 22d. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial-Transit 12/9/61</b>  |  | 23b. DATE THEREOF<br><b>12/9/61</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Algerian Mission</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>16 Rue du Dr Brunet, Tunis</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DEC 13 '61</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>W. S. Kline</b>  |  |  |  |



13  
FOR STATE  
HEALTH DEPT.

VS. A15ME  
SM 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                           |  |  |  |  |  |   |  |   |  |
|---|--|---------------------------|--|--|--|--|--|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                           |  |  |  |  |  |   |  |   |  |
| 14098 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14066   |  |                           |  |  |  |  |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery  |  |                           |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br>Maryland<br>b. COUNTY<br>Montgomery<br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Silver Spring, Maryland<br>d. STREET ADDRESS<br>202 Southampton Drive |  |  |  |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Takoma Park<br>c. LENGTH OF STAY IN 1b<br>DOA<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>Washington Sanitarium and Hospital   |  |                           |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |   |  |
| 3. NAME OF<br>(Type or print)<br>Mr. Alexander Gordon Fant  |  |                           |  | 4. DATE OF DEATH<br>December 19, 1961  |  |  |  |   |  |   |  |
| 5. SEX<br>Male  |  | 6. COLOR OR RACE<br>White |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br>April 12, 1912/49                                  |  | 9. AGE (In years last birthday)<br>49 yrs.                            |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Drug Clerk   |  |                           |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  |  | 11. BIRTHPLACE (State or foreign country)<br>Washington, D.C.         |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.        |  |
| 13. FATHER'S NAME<br>Alexander John Fant  |  |                           |  | 14. MOTHER'S MAIDEN NAME<br>Helen Schroat HARENBERG  |  |  |  | Address<br>RUTH K FANT 202 S. Hampton Dr.                             |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br>No  |  |                           |  | 16. SOCIAL SECURITY NO.<br>No  |  |  |  | 17. INFORMANT<br>RUTH K FANT 202 S. Hampton Dr.                       |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 420.1 Coronary occlusion<br>DUE TO<br>(b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br>Sudden  |  |                           |  |  |  |  |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                           |  |  |  |  |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |                           |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br>19  |  |                           |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town)<br>(County)<br>(State)                            |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)<br>12-19-61 |  |                           |  |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br>Frank J. Broschant  |  |                           |  | DATE SIGNED  |  |  |  |   |  |   |  |
| EXAMINER'S NAME (Type)<br>FRANK J. Broschant  |  |                           |  |  |  |  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |                           |  | 22b. DATE THEREOF<br>12-21-61  |  | 22c. NAME OF CEMETERY OR CREMATORY<br>Rock Creek Cemetery              |  | 22d. LOCATION (City, town, or county)<br>(State)<br>Washington, D. C. |  |   |  |
| 23. FUNERAL DIRECTOR<br>Deal Funeral Home   |  |                           |  | ADDRESS<br>4812 Ga. Ave., N.W., Wash. DC   |  |  |  | 24a. REC'D BY REGISTRAR   |  | 24b. REGISTRAR'S SIGNATURE                    |  |

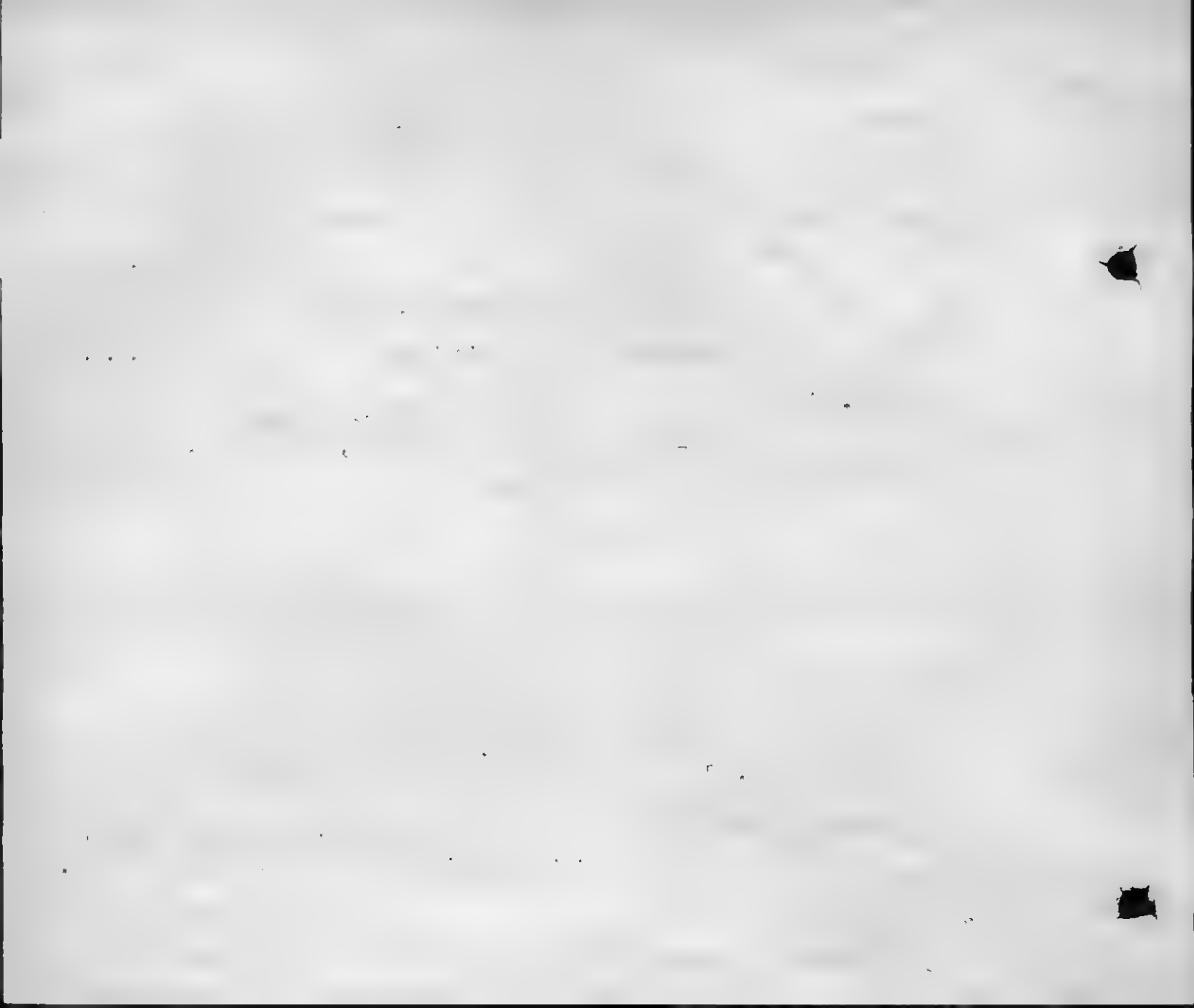
DEC 21 '61



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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14099  
14067  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY IN b<br><b>75 Days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>The Clinical Center</b> |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Virginia</b><br>b. COUNTY<br><b>Norfolk</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Norfolk</b><br>d. STREET ADDRESS<br><b>1330 Monterey Avenue</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>NANCY ANN FARLEY</b>  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 11, 1961</b>  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>September 26, 1934</b>   |  |
| 9. AGE (in years if under 1 year, if under 24 hours last birthday)<br><b>27 yrs</b>  |  | 10. AGE (in years if under 1 year, if under 24 hours last birthday)<br><b>27 yrs</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Secretary</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Secretarial</b>   |  |
| 11. PLACE, County & State, or foreign country<br><b>Michigan</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Spencer E. Kipp</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Erma Staggs</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>229-42-4873</b>   |  |
| 17. INFORMANT<br><b>The Medical Record</b>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intracerebral Hemorrhage</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Hypoplastic Anemia</b><br>(c) <b>DUE TO</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>13 hours</b><br><b>10 months</b> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 27, 1961</b> , to <b>December 11, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 11, 1961</b> , and that death occurred at <b>12:25 PM</b> , from the causes and on the date stated above.                               |  |   |  |
| 22a. SIGNATURE<br><b>Russell R. Moores</b>   |  | 22b. DATE SIGNED<br><b>12-12-61</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>RUSSELL R. MOORES, M.D.</b>   |  | 22d. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>   |  |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF<br><b>REMOVAL 12-12-61</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. W. Ellis - Wash D.C.</b>   |  | 24b. ADDRESS  |  |
| 25a. REC'D BY REGISTRAR<br><b>DEC 15 '61</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Wm. S. Harris</b>  |  |



## CERTIFICATE OF DEATH

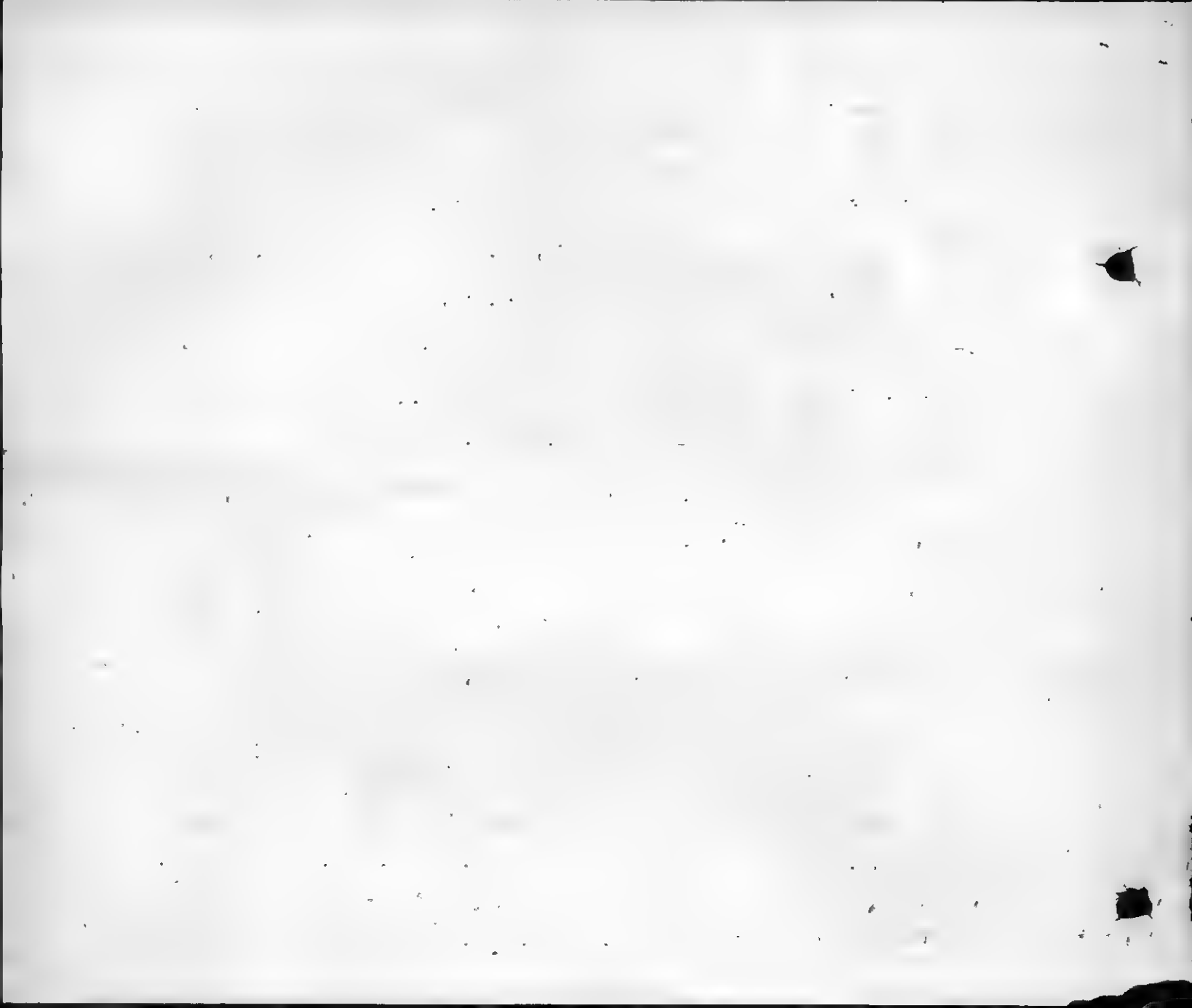
Reg. Dist. No. 14068

14100

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b><br>c. LENGTH OF STAY IN 1b<br><b>Rockville</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>106 Charles Street</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b><br>d. STREET ADDRESS<br><b>106 Charles Street</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print) <b>CHARLES</b> First <b>WILLIAM</b> Middle <b>FAWLEY, Sr.</b> Last   |                                  | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>16,</b> Year <b>1961</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>Sept. 10, 1879</b>                                   |
| 9. AGE (In years last birthday)<br><b>82</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>10</b> Hours <b>19</b> Min.  | 11. IF UNDER 24 HRS.<br>Months <b>6</b> Days <b>10</b> Hours <b>19</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret.-Farmer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>William B. Fawley</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret A. Wright</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>220-26-6841</b>   |   |
| 17. INFORMANT<br><b>Robert B. Fawley-Item# 2</b>   |                                  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH WITH METASTASES</b><br>151X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTEROSCLEROTIC HEART DISEASE</b><br>DUE TO<br>(c)<br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>6 MOS.</b><br><b>10 YRS.</b> |                                  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |   |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |                                  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  |   |   |
| 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/>   |                                  |   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  |   |   |
| 20f. (City or town) (County) (State)   |                                  |   |   |
| 21. I certify that I attended the deceased from <b>12-16</b> , 1961, to <b>12-16</b> , 1961, that I last saw the deceased alive on <b>12-16</b> , 1961, and that death occurred at <b>7:35 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>615 W. Montg. Ave., Rockville, Md.</b> DATE SIGNED <b>12/16/61</b>   |                                  |   |   |
| ACTUAL SIGNATURE <b>W.G. Hall</b> M.D. <b>615 W. Montg. Ave. Rockville, Md.</b>  |                                  |   |   |
| PHYSICIAN'S NAME (Type) <b>W.G. Hall</b>   |                                  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                                  |   |   |
| 22b. DATE THEREOF <b>12/19/61</b>  |                                  |   |   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>   |                                  |   |   |
| 22d. LOCATION (City, town, or county) (State) <b>Beallsville, Maryland</b>   |                                  |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</b> ADDRESS   |                                  |   |   |
| 24a. REC'D BY REGISTRAR <b>DEC 20 '61</b>  |                                  |   |   |
| 24b. REGISTRAR'S SIGNATURE <b>William S. Kuma</b>  |                                  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





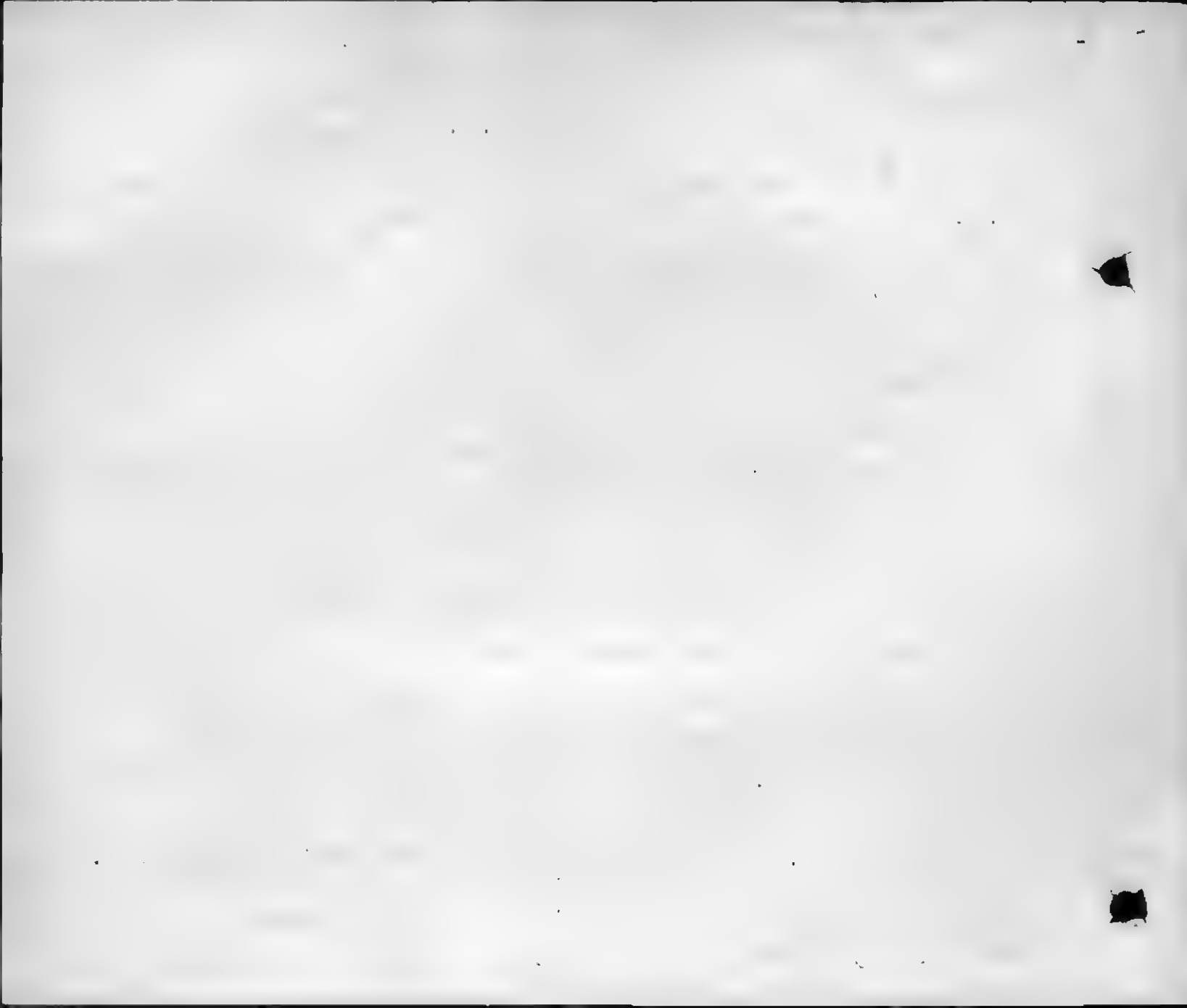
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The attending physician and the funeral director must completely fill in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14069

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>MONTGOMERY  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>N. C.<br>b. COUNTY<br>TARAWA TARRACE |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>BETHESDA (RURAL)   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>TARAWA TARRACE  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>U. S. Naval Hospital   |  | d. STREET ADDRESS<br>3389 HAGARU DR.  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>JOSEPHINE PATRICA FELLOWS  |  | 4. DATE OF DEATH<br>DECEMBER 16 1961  |  |
| 5. SEX<br>FEMALE   |  | 8. DATE OF BIRTH<br>1 DECEMBER 1911   |  |
| 6. COLOR OR RACE<br>CAUCASIAN  |  | 9. AGE (In years) IF UNDER 1 YEAR<br>47 yrs. Months Days  |  |
| 7. MARRIED<br>NEVER MARRIED<br>WIDOWED<br>DIVORCED   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE                                   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br>ILLINOIS  |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 13. FATHER'S NAME<br>WALTER WALSH  |  | 14. MOTHER'S MAIDEN NAME<br>HELENE PORZEL   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br>No   |  | 16. SOCIAL SECURITY NO.<br>17. INFORMANT<br>Husband: Robert Fellows,  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br>171X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>Pneumonia - Asphyxiation<br>Metastatic Carcinoma of Cervix<br>General Debilitation |  | INTERVAL BETWEEN ONSET AND DEATH<br>2 yrs<br>4 months   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)<br>20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br>19<br>20d. INJURY OCCURRED<br>While at work<br>No While at work<br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)                               |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21. I certify that (I) (this hospital) attended the deceased from JULY 20 1961 to DECEMBER 16 1961, that (I) (we) last saw the deceased alive on DEC 16 1961, and that death occurred at 0640 from the causes and on the date stated above.  |  | 22b. DATE SIGNED<br>12-16-61  |  |
| 22a. SIGNATURE<br>Louis E. Poter   |  | 22c. PHYSICIAN'S NAME (Type)<br>LOUIS E. POTER, M.D.  |  |
| 22d. ADDRESS<br>U. S. Naval Hospital, Bethesda, Md.  |  | 22e. ATTENDING PHYS.<br>MED. DIRECTOR<br>STAFF PHYS.  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Dec. 21, 1961   |  | 23b. DATE THEREOF   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Boniface Cemetery  |  | 23d. LOCATION (City, town or county) (State)<br>Chicago, Ill.   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>Frank A. Humphrey  |  | 25a. REC'D BY REGISTRAR<br>DATE DEC 21 '61  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Wanda S. Kenna   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14102

## CERTIFICATE OF DEATH

14070

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b <u>14 hrs - 10 min</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>                                     |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>d. STREET ADDRESS <u>6506 Highland Ave</u> |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Edward</u><br>First Middle Last  |  | 4. DATE OF DEATH <u>December 3, 1961</u><br>Date of Death Month Year                                   |  | 5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |
| 8. BIRTH DATE <u>October 14, 1904</u><br>Age (In years last birthday) <u>57</u> yrs.  |  | 9. AGE (In years last birthday) <u>57</u> yrs.   |  | 10. IF UNDER 1 YEAR: Months Days Hours M.n.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>   |  |  |  |
| 13. FATHER'S NAME <u>James W. Fielding</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Sallie Bailey</u>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>578-01-7983 Hospital Record.</u>   |  |  |  |
| 16. SOCIAL SECURITY NO. <u>578-01-7983</u>  |  |  |  | 17. INFORMANT <u>Hospital Record.</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>162.1</u> DUE TO <u>neoplastic carcinoma</u><br>Conditions, if any, which gave rise to immediate cause (b) <u>162.1</u> DUE TO <u>neoplastic carcinoma</u><br>(a), stating the underlying cause last. (c) <u>neoplastic carcinoma</u> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)           |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  |
| 20f. (City or town)   |  | 20g. (County)  |  | 20h. (State)  |  |  |  |
| 21. I certify that (I) (this physician) attended the deceased from <u>Feb 1961</u> to <u>Dec 3, 1961</u> that (I) (we) last saw the deceased alive on <u>Dec 3, 1961</u> and that death occurred at <u>11:30 PM</u> from the causes and on the date stated above.   |  |  |  |   |  |  |  |
| 22a. SIGNATURE <u>Boris Rabin</u>   |  | 22b. DATE SIGNED <u>December 4, 1961</u>   |  | 22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN, M.D.</u>  |  |  |  |
| 22d. ADDRESS <u>1019 University Blvd, East Baltimore</u>  |  | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                       |  |   |  |  |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>Dec. 6, 1961</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>   |  |  |  |
| 23d. LOCATION (City, town or county) <u>Prince George Co</u>  |  | 23e. (State) <u>Maryland</u>   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>   |  | 24b. ADDRESS <u>254 Carroll Rd NW DC</u>   |  | 25a. REC'D BY REGISTRAR <u>DEC 6 '61</u>  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>  |  |  |  |   |  |  |  |

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15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

|  |                               |  |                                   |
|--|-------------------------------|--|-----------------------------------|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>  |                               | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>     |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |                               | c. LENGTH OF STAY IN 1b <u>2 days</u>  |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>  |                               | d. STREET ADDRESS <u>19819 Rosesteel Ave</u>   |                                   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Clyde</u> Middle <u>William</u> Last <u>Fiery</u>  |                               | 4. DATE OF DEATH <u>Dec. 10 1961</u>   |                                   |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/9/1883</u> |
| 9. AGE (In years last birthday) <u>78</u>  |                               | 10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>8</u> Hours <u>15</u> Min. <u>0</u>   |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical engineer Govt.</u>   |                               | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>  |                                   |
| 13. FATHER'S NAME <u>Albert Riery</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Kathryn ? Unknown</u>  |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>no</u>  |                               | 16. SOCIAL SECURITY NO <u>no</u>   |                                   |
| 17. INFORMANT <u>Elizabeth Leary</u>   |                               | Address <u>19819-Rosesteel Ave.</u>  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>(a) IMMEDIATE CAUSE (e) <u>422.1</u> DUE TO <u>Congestive heart failure</u><br>(b) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>Myocardial hypertrophy</u><br>(c) <u>Generalized atherosclerosis</u> |                               | INTERVAL BETWEEN ONSET AND DEATH   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |                               |  |                                   |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |
| 20c. TIME OF INJURY: Month, Day, Year <u>12-9-1961</u><br>Hour a.m. <u>19</u> p.m. <u>19</u>   |                               | 20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 1955</u> to <u>12-10-1961</u> , that (I) <del>was</del> last saw the deceased alive on <u>12-9-1961</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.   |                               |  |                                   |
| 22a. SIGNATURE <u>Seruth T. Kimble</u>   |                               | 22b. DATE SIGNED   |                                   |
| 22c. PHYSICIAN'S NAME (Type) <u>Seruth T. Kimble</u>   |                               | 22d. ADDRESS <u>927 Pershing Drive Silver Spring, Md.</u>  |                                   |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>   |                               | 23b. DATE THEREOF <u>12/13/61</u>  |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEMETERY</u>   |                               | 23d. LOCATION (City, town or county) (State) <u>WASHINGTON D.C.</u>  |                                   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Ziska</u>   |                               | 25a. REC'D BY REGISTRAR <u>DEC 14 '61</u>  |                                   |
| 25b. REGISTRAR'S SIGNATURE <u>William E. Pimphrey</u>  |                               | 25c. ADDRESS <u>38434 GEORGIA AVENUE</u>   |                                   |
| 25d. CITY, STATE, ZIP <u>SILVER SPRING, MARYLAND</u>   |                               | 25e. DATE <u>DEC 14 '61</u>  |                                   |



# 1 FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |       |  |
|--|--|--|--|--|--|--|--|--|--|-------|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |  |  |  |  |       |  |
| 14104 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | 14072 |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b <u>DOA</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>   |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>2100 Reddie Drive</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |       |  |
| 3. NAME OF DECEASED (Type or print) <u>Francis</u> First <u>Figelman</u> Middle Last<br>5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>10/6/07</u><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>19</u> Hours <u>61</u> Min.   |  |  |  |  |  | 4. DATE OF DEATH <u>December 8, 19 61</u>  |  |  |  |       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Economist</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau of Foreign Commerce</u><br>11. BIRTHPLACE (State or foreign country) <u>New York</u><br>12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |  |  |  |  |  |  |  |  |       |  |
| 13. FATHER'S NAME <u>Joseph Figelman</u>   |  |  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Ethel Cohen</u>  |  |  |  |       |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u><br>16. SOCIAL SECURITY NO. <u>218389519</u><br>17. INFORMANT <u>Sophie Figelman-2100 Reedie Dr., SS, Md.</u>   |  |  |  |  |  | Address  |  |  |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |       |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> <u>Acute Myocardial Infarction</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis, left coronary artery</u><br>DUE TO (c) <u>Coronary Atherosclerosis</u><br>Sudden<br>Sudden<br>Unknown   |  |  |  |  |  |  |  |  |  |       |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |  |  |       |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |       |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  |  |  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)   |  |  |  |       |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DATE SIGNED <u>12-8-61</u> |  |  |  |  |  |  |  |  |  |       |  |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u><br>EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>   |  |  |  |  |  | Address (Street, city, town, or county)  |  |  |  |       |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |  |  |  |  | 22b. DATE THEREOF <u>12-10-61</u>  |  |  |  |       |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>New Montefiore Cem.</u>  |  |  |  |  |  | 22d. LOCATION (City, town, or country) (State) <u>Pinelawn, New York</u>   |  |  |  |       |  |
| 23. FUNERAL DIRECTOR <u>Bernard Danzansky &amp; Sons-3501 14th St. NW</u>  |  |  |  |  |  | 24a. REC'D BY REGISTRAR <u>11 61</u><br>24b. REGISTRAR'S SIGNATURE <u>C. J. A. [unclear]</u>   |  |  |  |       |  |





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14105

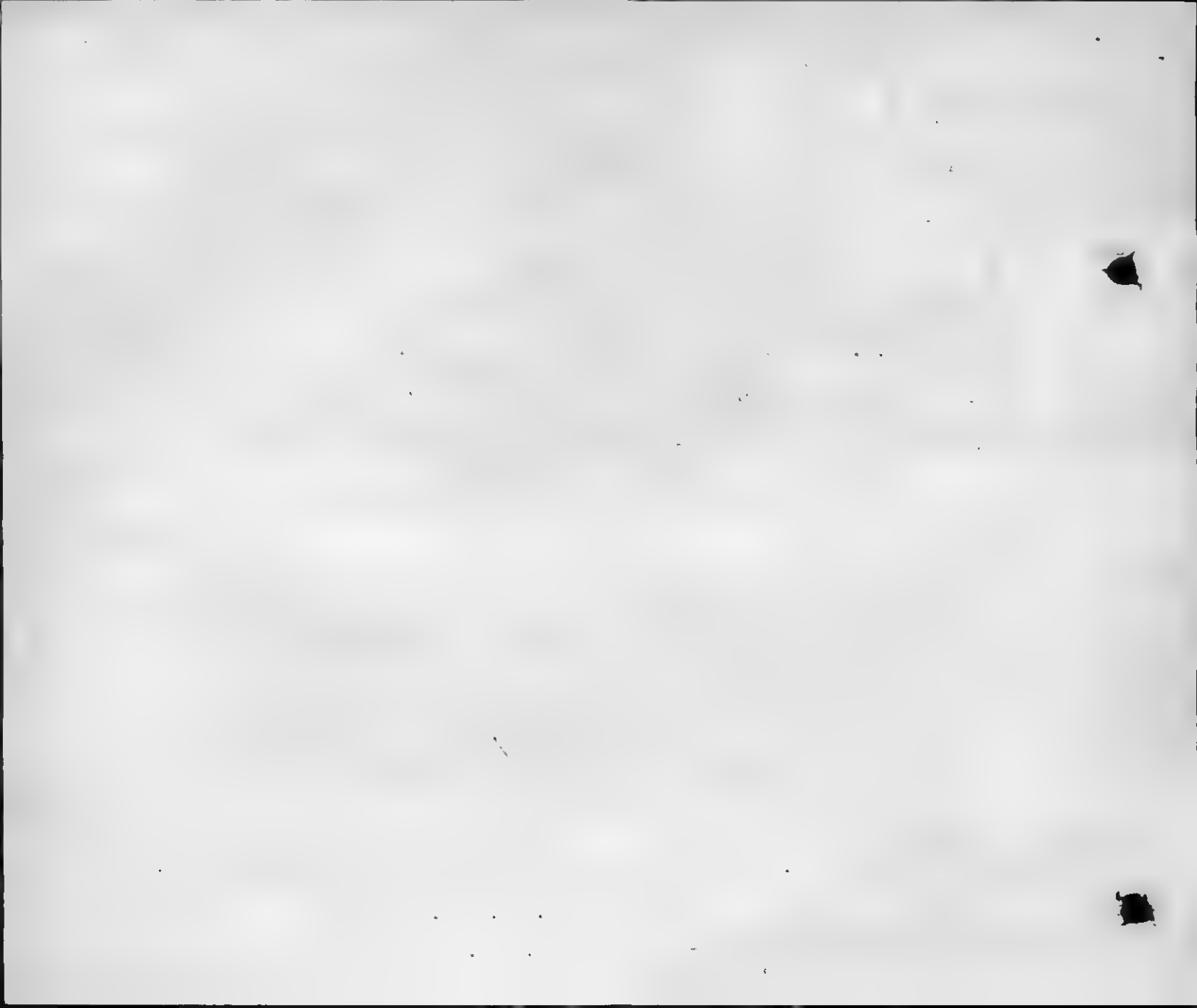
14073

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Olney</b><br>c. LENGTH OF STAY IN <b>1 day</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Montgomery</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville,</b><br>d. STREET ADDRESS <b>200 S Horners Lane</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <b>RAYMOND CLAY FISHER</b><br>5. SEX <b>Male</b><br>6. COLOR OR RACE <b>White</b><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH <b>8-24-05</b><br>9. AGE (In years, last birthday) <b>56</b> yrs. IF UNDER 1 YEAR: Months <b>12-</b> Days <b>22</b> Hours <b>19</b> Min. <b>61</b>  |  |  |  | <b>4. DATE OF DEATH</b> <b>12-22-1961</b><br>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>service sta. attendant oil</b><br>10b. KIND OF BUSINESS OR INDUSTRY<br>11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b><br>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  |
| 13. FATHER'S NAME <b>Nathaniel Clay Fisher</b><br>14. MOTHER'S MAIDEN NAME <b>Cora Mc Gaha</b>   |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown No</b><br>16. SOCIAL SECURITY NO. <b>217-03-4612</b><br>17. INFORMANT <b>Hospital records</b><br>Address  |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ATHEROSCLEROSIS</b><br>(c) <b>ARTERIAL HYPERTENSION</b>   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>30 HOURS</b><br><b>10 YEARS</b><br><b>10 YEARS</b>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>NEPHROSCLEROSIS - RENAL FAILURE</b>  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b><br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year <b>19</b><br>Hour a.m. <b>19</b> p.m.<br>20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |  |  | 21. I certify that, (I) (this hospital) attended the deceased from <b>27 DEC 1961</b> to <b>22 DEC 1961</b> that (I) (we) last saw the deceased alive on <b>22 DEC 1961</b> , and that death occurred <b>8 A.M.</b> from the causes and on the date stated above.<br>22a. SIGNATURE <b>Gordon S. Rosenberger</b> M.D.<br>22b. DATE SIGNED <b>22 DEC 1961</b><br>22c. PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger</b><br>22d. ADDRESS <b>316 W. MONTGOMERY BLVD ROCKVILLE, MARYLAND</b> |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b><br>23b. DATE THEREOF <b>12/26/61</b><br>23c. NAME OF CEMETERY OR CREMATORY <b>Potomac Meth. Ch. Cem.</b><br>23d. LOCATION (City, town or county) (State) <b>Potomac, Maryland</b>  |  |  |  | 24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</b><br>ADDRESS<br>25a. REC'D BY REGISTRAR <b>DEC 27 '61</b><br>25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>  |  |  |  |

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

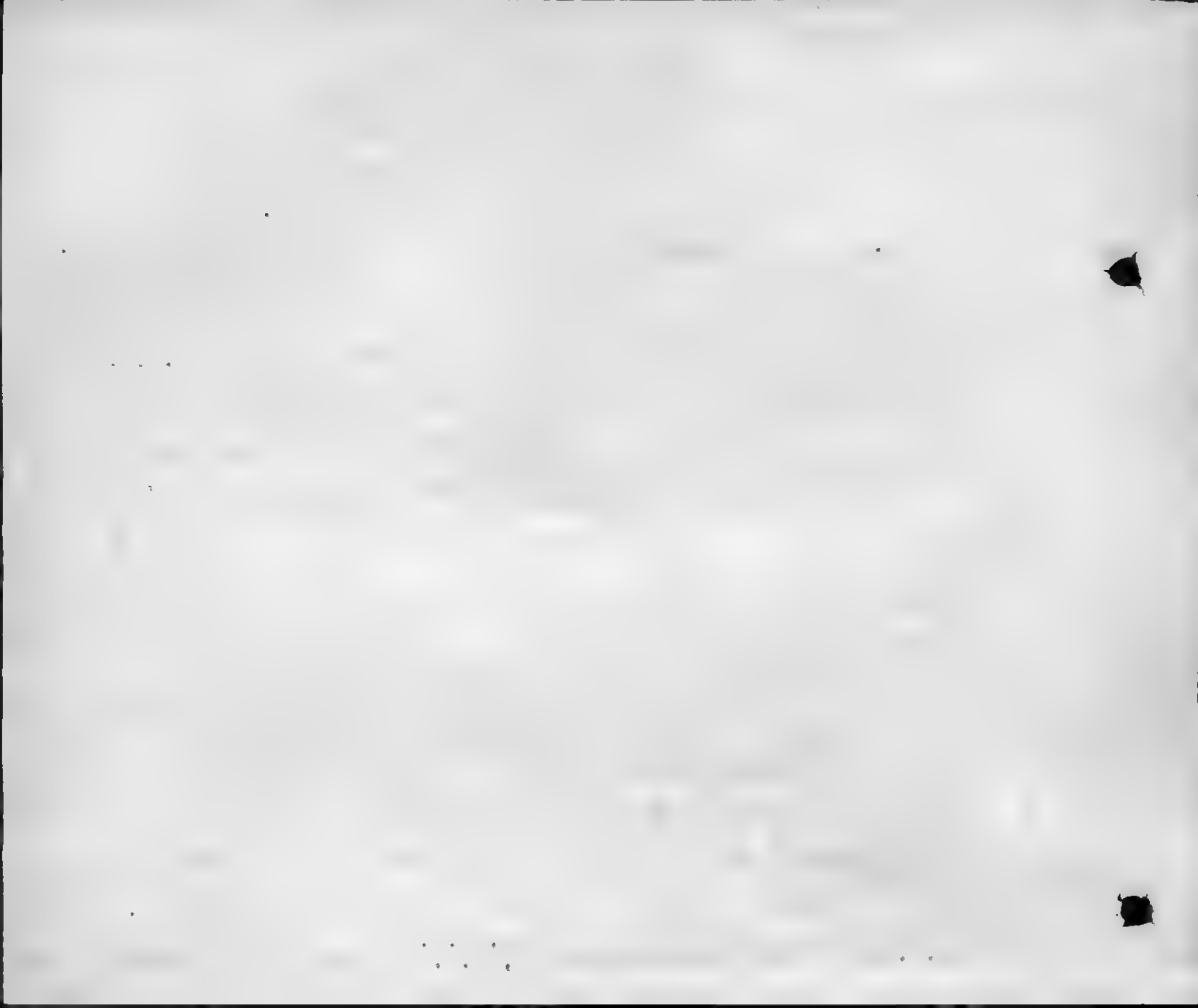
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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |  |  |  |  |  |  |
| 14106  |  |  |  |  |  |  |  |  |  |  |  |
| 14074  |  |  |  |  |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>c. LENGTH OF STAY IN 1b <u>MARYLAND</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>21 Thayer Avenue</u> |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>24 Silver Spring</u><br>d. STREET ADDRESS <u>721 Thayer Ave.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Howard Sturdevant Fisk</u><br>First Middle Last<br>4. DATE OF DEATH <u>December 20 1961</u><br>Month Day Year   |  |  |  |  |  | 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>2/1/78</u><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.   |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Star Newspaper Reporter</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>New York City</u><br>11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u><br>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>      |  |  |  |  |  | 13. FATHER'S NAME <u>Henry Clay Fisk</u><br>14. MOTHER'S MAIDEN NAME <u>Emma Jane Nutt</u>   |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16. SOCIAL SECURITY NO. <u>?</u> 17. INFORMANT <u>Katherine Fisk Bartley</u> Address <u>same as #2</u><br>(If yes, give war or dates of service)  |  |  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>420.1</u> DUE TO <u>CORONARY THROMBOSIS</u><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } DUE TO <u>ARTERIOSCLEROSIS</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Unknown</u> |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |  |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour e.m. p.m. <u>19</u>   |  |  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1834 Eye St. N.W. Washington D.C.</u><br>20f. (City or town) (County) (State)  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>November 16, 1961</u> to <u>December 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>December 18, 1961</u> , and that death occurred at <u>1:00 AM</u> , from the causes and on the date stated above.                   |  |  |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE <u>Theodore J. Abennethy</u><br>22c. PHYSICIAN'S NAME (Type) <u>Theodore J. Abennethy</u>   |  |  |  |  |  | 22b. DATE SIGNED<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22d. ADDRESS <u>1834 Eye St. N.W. Washington D.C.</u>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>12/22/61</u>  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery Washington, D.C.</u><br>23d. LOCATION (City, town or county) (State)  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>  |  |  |  |  |  | 25a. REC'D BY REGISTRAR <u>DEC 22 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>   |  |  |  |  |  |

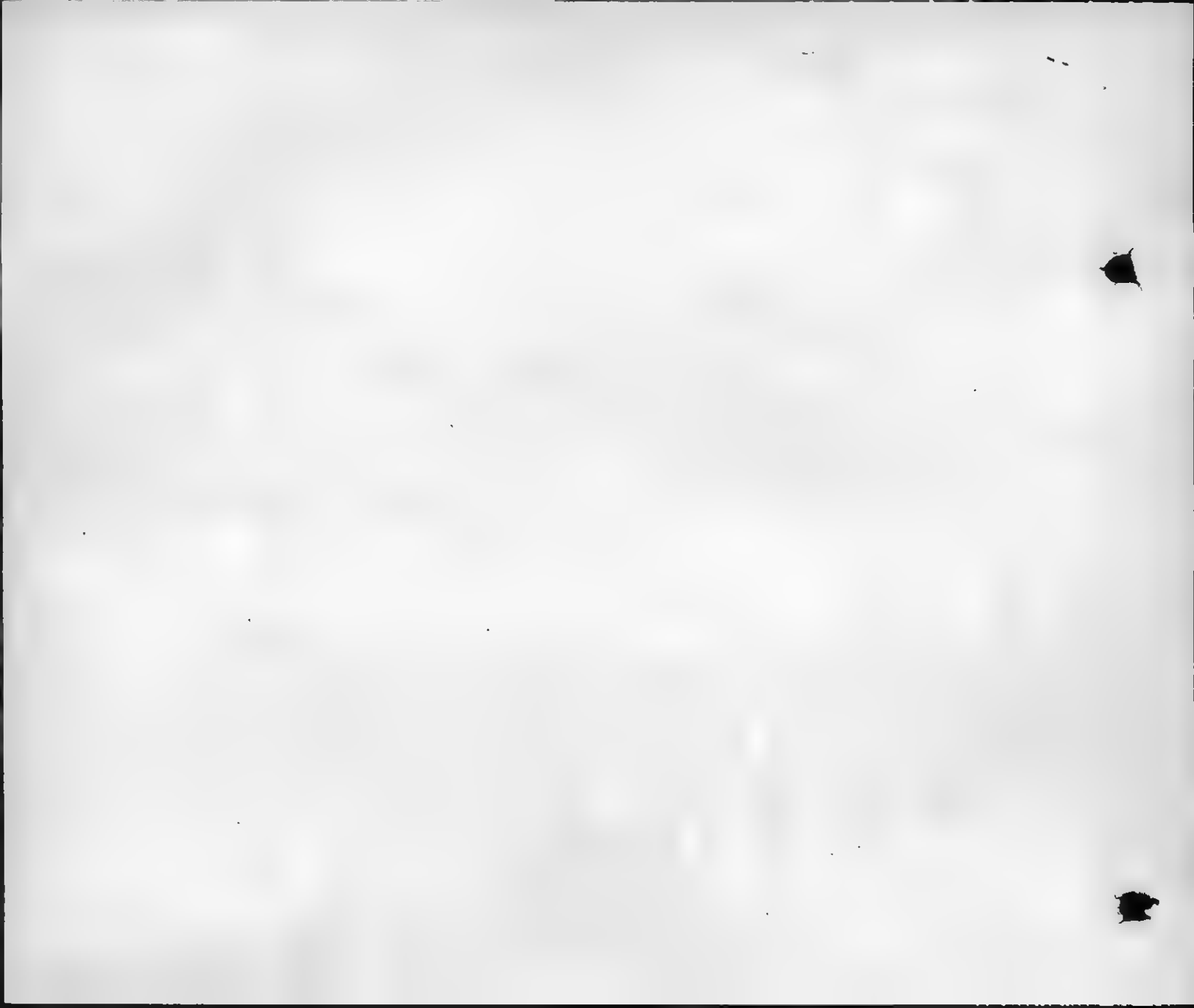


**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14107

14075

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  |   |  | c. LENGTH OF STAY IN 1b <u>16 da</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Nursing Home</u>  |  |   |  | d. STREET ADDRESS <u>4111 Leland St</u>  |  |   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Richard</u> Middle <u>Wilson</u> Last <u>Flournoy</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>6</u> Year <u>1961</u>  |  |   |  |
| 5. SEX <u>M</u>  |  | 6. COLOR OR RACE <u>W</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>May 20th 1878</u>                                   |  |
| 9. AGE (In years last birthday) <u>83</u> yrs  |  | IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |  | IF UNDER 24 HRS: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>   |  |   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |  |   |  |
| 13. FATHER'S NAME <u>Park Flournoy</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  |   |  | 16. SOCIAL SECURITY NO. <u>None</u>  |  |   |  |
| 17. INFORMANT <u>Addison H. Flournoy</u>   |  |   |  | Address <u>4111 Leland St. Bethesda, Md.</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |   |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u>  |  |   |  |  |  |   |  |
| 434.4 DUE TO (b) <u>Cardiac Irregularity</u>   |  |   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Old Age</u>   |  |   |  |  |  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>  |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE DETERMINED</u>   |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>a</u> m. <u>19</u> p. m.   |  |   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1940</u> to <u>Dec 6, 1961</u> , that (I) <del>was</del> last saw the deceased alive on <u>Dec 5, 1961</u> and that death occurred at <u>11:30</u> AM, from the causes and on the date stated above |  |   |  |  |  |   |  |
| 22a. SIGNATURE <u>Bradley D. Hodgkins</u> M.D.   |  |   |  | 22b. DATE SIGNED <u>Dec 6, 1961</u>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>BRADLEY D. HODGKINS</u>  |  |   |  | 22d. ADDRESS <u>4413 Bradley Lane</u>  |  |   |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>  |  | 23b. DATE THEREOF <u>12/7/61</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>   |  | 23d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>   |  |   |  | 25a. REC'D BY REGISTRAR <u>DEC 7 '61</u> 25b. REGISTRAR'S SIGNATURE <u>C. L. S. [Signature]</u>  |  |   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

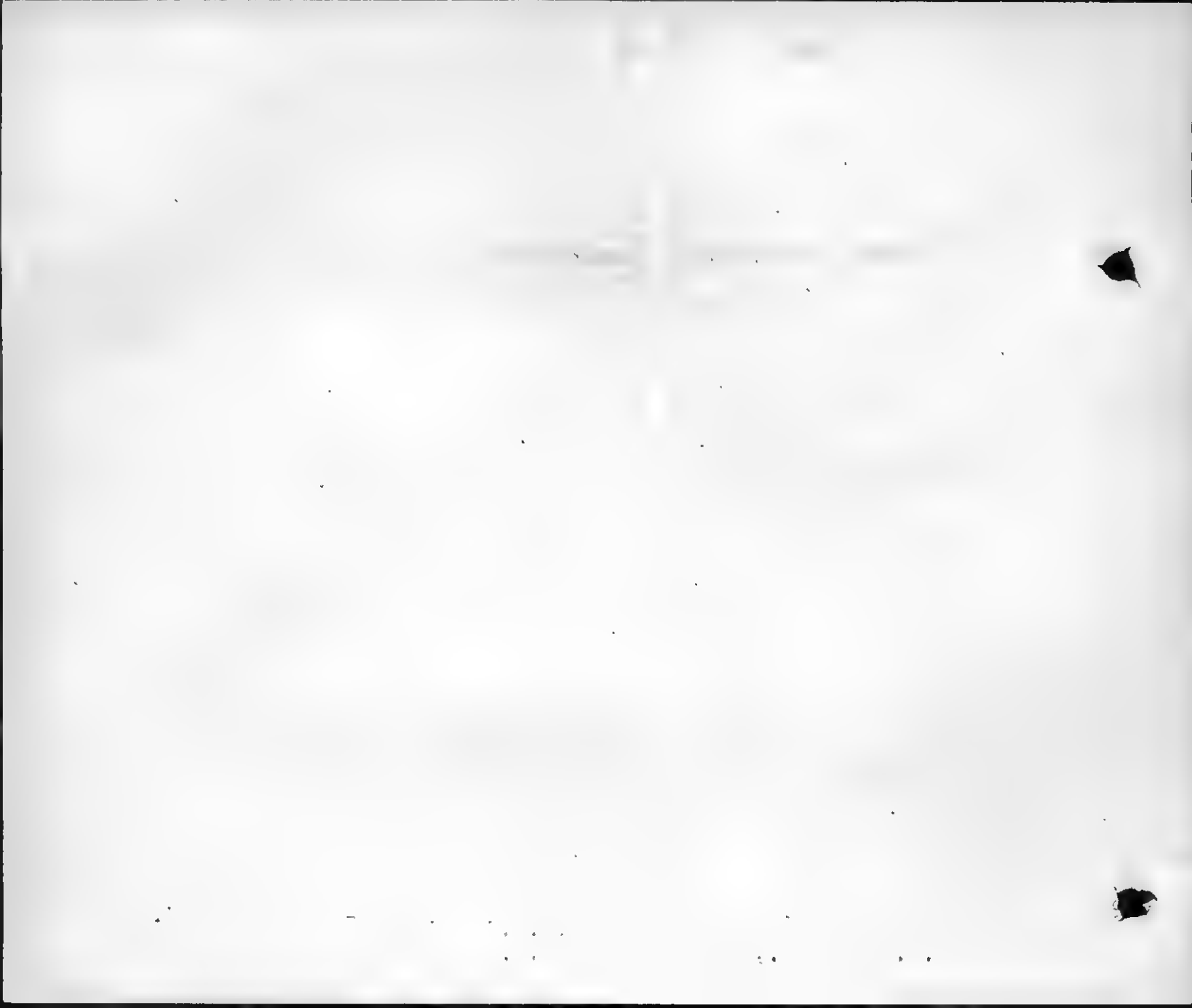
14108

## CERTIFICATE OF DEATH

Reg. Dist. No. 14076

|   |                             |   |   |
|---|-----------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u><br>c. LENGTH OF STAY IN 1b <u>28 days</u>   |                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>D.C.</u><br>b. COUNTY <u>Washington</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>+ 1X</u><br>d. STREET ADDRESS <u>6010 Broad Branch Rd. NW</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Evelyn</u> Middle <u>Susan</u> Last <u>Foresman</u>   |                             | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>19</u> Year <u>1961</u>  |   |
| 5. SEX <u>Fe</u>  | 6. COLOR OR RACE <u>wh.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>12-9-98</u>   |
| 9. AGE (In years last birthday) <u>63</u> yrs   |                             | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   | IF UNDER 24 HRS<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Economist</u>   |                             | 10b. KIND OF BUSINESS OR INDUSTRY <u>Mgr. cafeterias</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Md.</u>  |                             | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |   |
| 13. FATHER'S NAME <u>Samuel Bond</u>  |                             | 14. MOTHER'S MAIDEN NAME <u>Cordelia Davis</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)   |                             | 16. SOCIAL SECURITY NO. <u>?</u>  |   |
| 17. INFORMANT <u>Hospital chart</u>   |                             | Address <u>  </u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |                             |   |   |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation-Rt Hrt Failure</u> (b) <u>Congestive Cardiac Failure</u> (c) <u>Hypertensive Cardio-Renal Complex</u>   |                             |   |   |
| INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u><br><u>3 weeks</u><br><u>years</u>  |                             |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>  |                             |   |   |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                             |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                             | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>   |                             | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                             | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>11-19-</u> , 19 <u>61</u> , to <u>12-19-</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec 18</u> , 19 <u>61</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above. |                             |   |   |
| ACTUAL SIGNATURE <u>Robert A. Hare</u>  |                             | ADDRESS (Street, city or town, state) <u>7600 Carroll Ave, 12/19/61</u>   |   |
| PHYSICIAN'S NAME (Type) <u>Robert A. Hare, M.D.</u>   |                             | DATE SIGNED <u>12/19/61</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>   |                             | 22b. DATE THEREOF <u>12/22/61</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. - Arlington, Virginia</u>   |                             | 22d. LOCATION (City, town, or county) (State)   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St., N.W.</u>   |                             | 24a. REC'D BY REGISTRAR <u>DEC 22 '61</u>   |   |
| ADDRESS <u>Wash. D.C.</u>   |                             | 24b. REGISTRAR'S SIGNATURE <u>  </u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

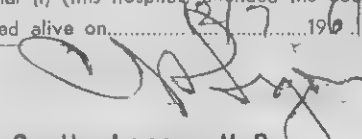

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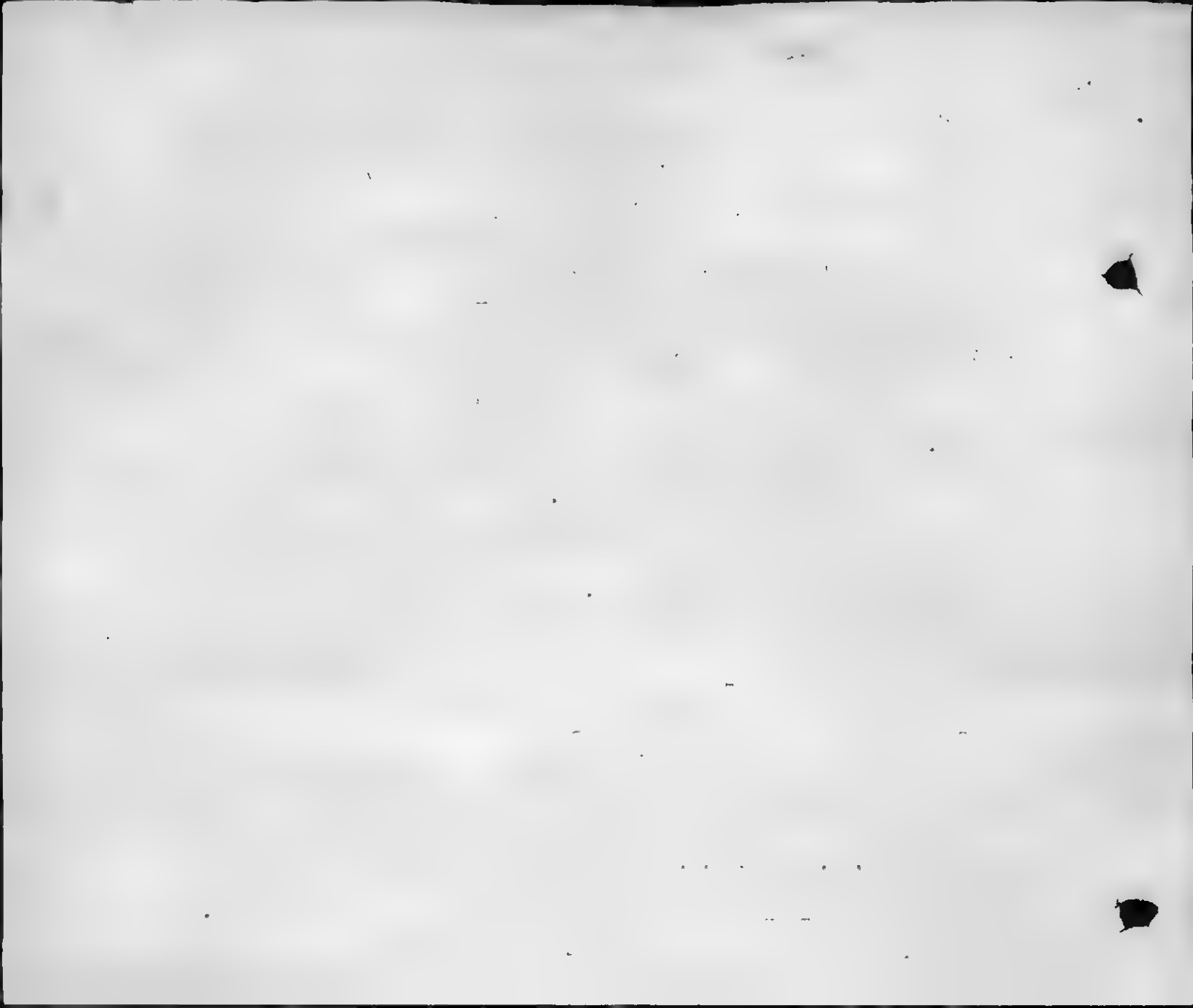
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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b> |  |  |  |  |  |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Olney</b>   |  |  |  |  | c. LENGTH OF STAY IN lb.<br><b>17 days</b>   |  |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Derwood,</b>  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Montgomery General Hospital</b>   |  |  |  |  | d. STREET ADDRESS<br><b>Box 66</b>   |  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>ALFRED LLOYD FRALEY</b>  |  |  |  |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>7</b> Year <b>19 61</b>   |  |  |  |  |  |  |  |  |  |
| 5. SEX<br><b>male</b>  |  |  |  |  | 6. COLOR OR RACE<br><b>white</b>   |  |  |  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |
| 8. DATE OF BIRTH<br><b>8-26-93</b>   |  |  |  |  | 9. AGE (In years last birthday)<br><b>68</b> yrs.  |  |  |  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>(RETIRED) MECHANIST</b>  |  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Garage</b>   |  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |  |  |  |  |
| 13. FATHER'S NAME<br><b>John Fraley</b>  |  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Hinda Adamson</b>   |  |  |  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown)<br><b>no unknown</b>  |  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  |  |  |  | 17. INFORMANT<br><b>Hospital records</b>   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA.</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>ADENOCARCINOMA OF STOMACH WITH METASTASIS TO</b><br>(a), stating the underlying cause last. (c) <b>THE DIAPHRAGM.</b> |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |  |  |  |  |  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  |  |  |  |  |  |  | 20f. (City or town, (County) (State)   |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>8:45 PM</b> to <b>12/7, 1961</b> , that (I) (we) last saw the deceased alive on <b>12/6, 1961</b> , and that death occurred <b>12/7, 1961</b> , from the causes and on the date stated above.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br>  |  |  |  |  |  |  |  |  |  | 22b. DATE SIGNED<br><b>12/8/61</b>   |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>C. H. LIGON, M.D.</b>   |  |  |  |  |  |  |  |  |  | 22d. ADDRESS<br><b>SANDY SPRING, MARYLAND</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  |  |  |  |  |  |  |  | 23b. DATE THEREOF<br><b>12-11-61</b>   |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Luke's Lutheran</b>   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Redland Mont. Maryland</b>  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Francis H. Barber</b>   |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 13 '61</b>   |  |  |  |  |
| ADDRESS<br><b>Laytonsville, Maryland</b>   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>                                      |  |  |  |  |



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

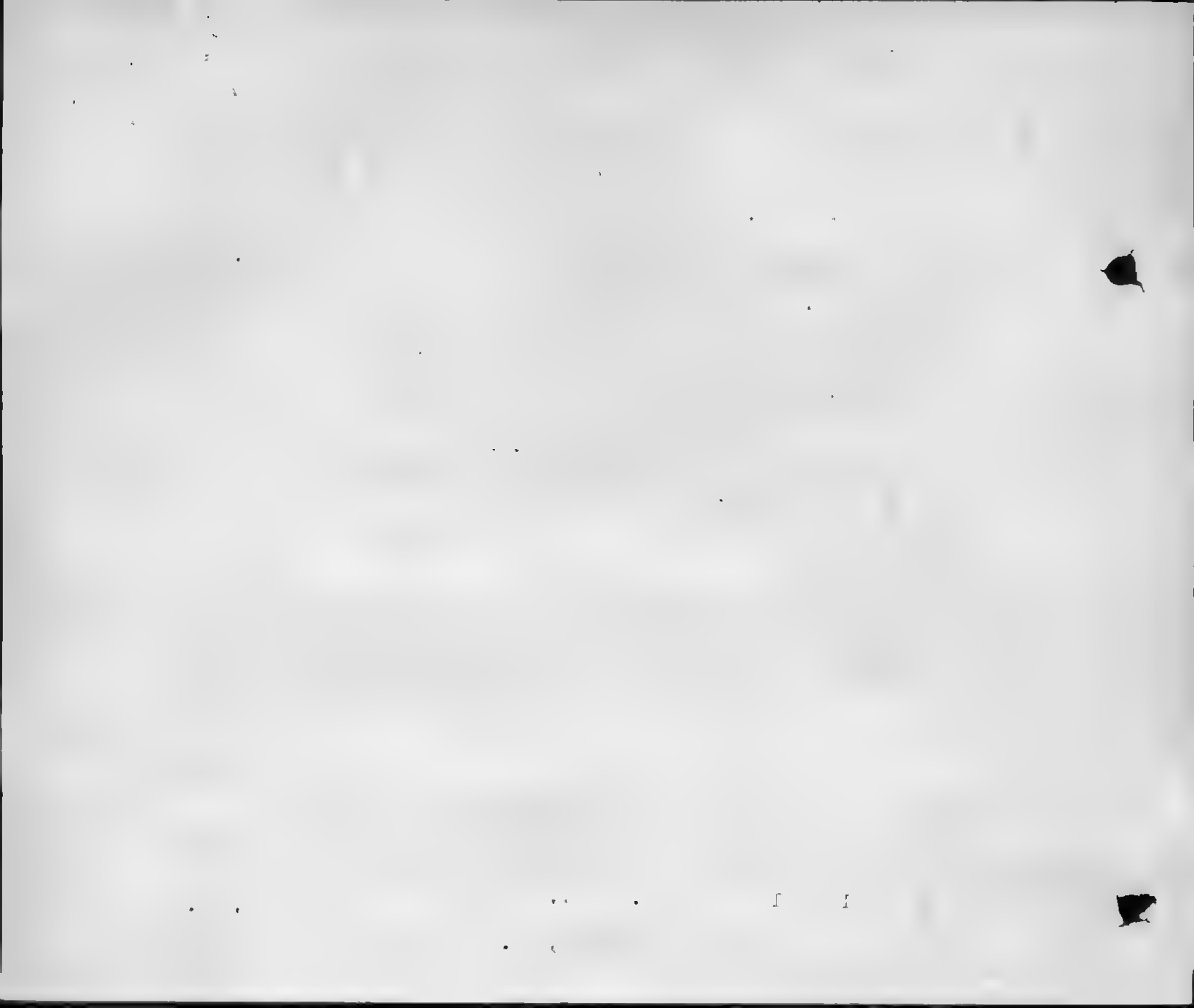
14110

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14078

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>                |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Gaithersburg</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Gaithersburg</u> (rural)  |  |  |  |
| c. LENGTH OF STAY in 1b<br><u>10 min.</u>   |  |  |  | d. STREET ADDRESS<br><u>Metropolitan Grove</u>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>8 Russell Ave., Drs. office</u>  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Charles F Frazier</u>  |  |  |  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>4</u> Year <u>19 61</u>   |  |  |  |
| 5. SEX<br><u>male</u>   |  | 6. COLOR OR RACE<br><u>col.</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>11/ 12/1899</u>                       |  |
| 9. AGE (in years last birthday)<br><u>62</u> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>laborer</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |  |  | 13. FATHER'S NAME<br><u>Cy Frazier</u>   |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Mary Noland</u>  |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>                                    |  |  |  |
| 16. SOCIAL SECURITY NO.<br><u>M.C. Police</u>   |  |  |  | 17. INFORMANT<br><u>M.C. Police</u>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Hemorrhage</u>  |  |  |  |  |  |  |  |
| DUE TO (b) <u>Rupture of aortic aneurysm into</u>   |  |  |  |  |  |  |  |
| DUE TO (c) <u>large bronchus of lung at</u>   |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>    |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                         |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u>  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
|   |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12/5/61</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |  |  | 22b. DATE THEREOF<br><u>12/9/61</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>St. Rose.,</u>      |  |
|   |  |  |  | 22d. LOCATION (City, town, or country) (State)<br><u>Cloppers, Md.</u>   |  |  |  |
| 23. FUNERAL DIRECTOR<br><u>Robert L. Snowden</u>  |  |  |  | ADDRESS<br><u>Rockville, Md.</u>   |  |  |  |
| 24a. REC'D BY REGISTRAR<br><u>DEC 14 '61</u>  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><u>C. L. S. Hines</u>  |  |  |  |

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



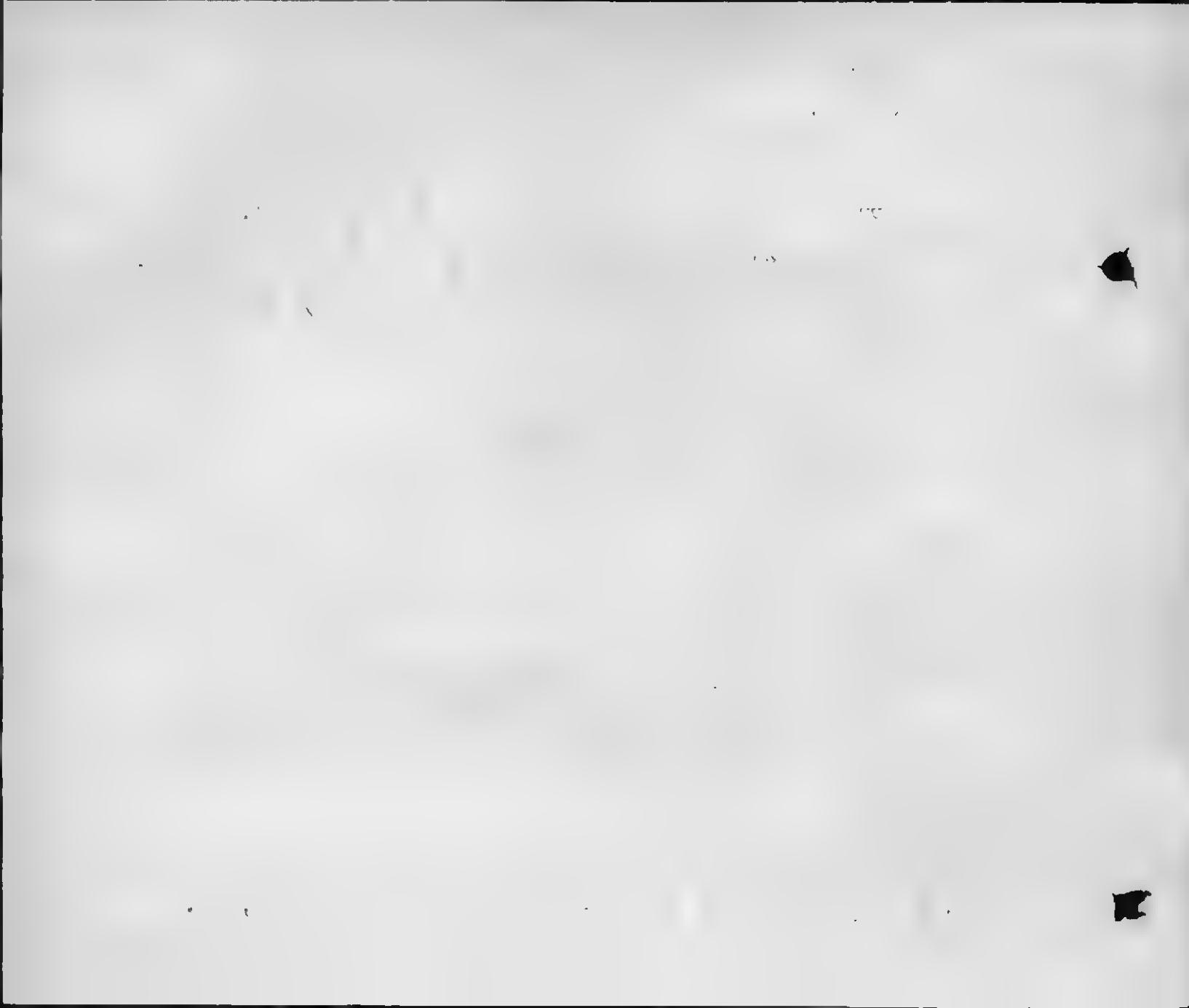
# 1 FOR STATE HEALTH DEPT M

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 14111 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14079

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>4 hrs.</b>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Suburban Hospital</b>   |  |   |  | e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>  |  |   |  |
| f. STREET ADDRESS<br><b>5209 Gretchen St.</b>  |  |   |  | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Deborah Lynn Gabriel</b>   |  |   |  | 4. DATE OF DEATH<br><b>December 21, 1961</b>   |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1/7/58</b>             |  |
| 9. AGE (in years last birthday)<br><b>3 yrs.</b>   |  | 10. IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13. FATHER'S NAME<br><b>Roger P. Gabriel</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Barbara Trumpp</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>104-10-10000</b>   |  |   |  |
| 17. INFORMANT<br><b>Hosp. Record</b>   |  |   |  | Address  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shock</b><br>916.0 DUE TO (b) <b>1st 2nd + 3rd degree burns involving about 80% of body</b><br>DUE TO (c) <b>80% of body</b>   |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  |  |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Clothes caught on fire - playing with cigarette lighter</b>   |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br><b>9:12 pm 12-21-1961</b>  |  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work  |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>  |  |   |  | 20f. (City or town) (County) (State)<br><b>Kensington Montgomery Md.</b>   |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Frank J. Broschew</b>  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type) <b>FRANK J. BROSCHEW</b>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |   |  | 22b. DATE THEREOF<br><b>12-23-1961</b>   |  |   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>   |  |   |  | 22d. LOCATION (City, town, or country) (State)<br><b>Rockville, Md.</b>  |  |   |  |
| 23. FUNERAL DIRECTOR<br><b>Joseph L. Davis, Inc.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>DEC 26 '61</b>   |  |   |  |
| ADDRESS <b>1750 Pa. Ave. NW, Wash. D.C.</b>  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |  |   |  |



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14112

CERTIFICATE OF DEATH

14080

|   |  |   |  |
|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> MARYLAND<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u><br>c. LENGTH OF STAY IN IL <u>15 mo</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>16550 Emory Lane</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u><br>d. STREET ADDRESS <u>16550 Emory Lane</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>JESSIE LORETTA GAUL</u>  |  | <b>4. DATE OF DEATH</b> <u>December 22 1961</u>   |  |
| <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>W</u><br><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b> <u>July 16, 1879</u> <b>9. AGE</b> (In years, if UNDER 1 YEAR, if UNDER 24 HRS., last birthday) <u>82</u> yrs. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Housewife</u>  |  | <b>11. BIRTH PLACE</b> (County & State, or foreign country) <u>New York</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>   |  |
| <b>13. FATHER'S NAME</b> <u>William James Morrison</u>  |  | <b>14. MOTHER'S MAIDEN NAME</b> <u>Ellen O'Brien</u>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>---</u> <b>17. INFORMANT</b> <u>Mrs Katherine Mather</u> Address <u>16550 Emory Lane, Rockville, Md.</u>   |  |   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>450.0</u> DUE TO <u>Uremia</u><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last: <u>Arteriosclerosis, generalized</u><br>DUE TO <u>Uremia</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Uremia</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u><br><u>Yrs</u> |  |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| <b>20c. TIME OF INJURY</b> Hour <u>---</u> a.m. <u>---</u> p.m. Month, Day, Year <u>19</u>  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>---</u> <b>20f. (City or town)</b> (County) (State)  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept 8, 1959</u> <b>to</b> <u>12/22/61</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>12/22/61</u> , <b>and that death occurred at</b> <u>11:00 A.M.</u> <b>from the causes and on the date stated above.</b>   |  |   |  |
| <b>22a. SIGNATURE</b> <u>[Signature]</u> <b>22b. DATE SIGNED</b> <u>12/22/61</u>  |  | <b>22c. PHYSICIAN'S NAME</b> (Type) <u>C.H.L. [Signature]</u> <b>22d. ADDRESS</b> <u>Sandy Spring, Md.</u>  |  |
| <b>23a. BURIAL, CREMATION, or REMOVAL</b> (Specify) <u>Removal</u> <b>23b. DATE THEREOF</b> <u>Dec. 26 1961</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Maple Grove Park</u>   |  | <b>23d. LOCATION</b> (City, town or county) (State) <u>Hackensack New Jersey</u>  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Francis H. Barber</u> <b>ADDRESS</b> <u>Laytonsville, Maryland</u>   |  | <b>25a. REC'D BY REGISTRAR</b> <u>DEC 29 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>   |  |





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 14113 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14081

FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the cause should be stated in the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |  |  |  | c. LENGTH OF STAY (In 1b) <u>1 hour 40 min</u>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>   |  |  |  | e. STREET ADDRESS <u>14105 Chelmsford Road</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Lillian NMN Gealt</u>  |  |  |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>31</u> Year <u>1961</u>  |  |  |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>white</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>June 30, 1923</u>               |  |
| 9. AGE (In years last birthday) <u>38</u> yrs.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 9. AGE (In years last birthday) <u>38</u> yrs.         |  |
| 11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |  |  |
| 13. FATHER'S NAME <u>Morris Brenner</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>REBECCA</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Washington Sanitarium &amp; Hospital Records</u> Address   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cornary occlusion</u><br>4-29-1 DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____ |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>    |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) _____ (County) _____ (State) _____ |  |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>    |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u>   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>   |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>   |  |  |  | 22b. DATE THEREOF <u>JAN 2-1962</u>   |  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>MONTEFIORE CEM</u>   |  |  |  | 22d. LOCATION (City, town, or country) (State) <u>MONTGOMERY CO PENN</u>  |  |  |  |
| 23. FUNERAL DIRECTOR <u>B Dargunsky 4 Ave 3501-HA ST NW</u>  |  |  |  | 24a. REC'D BY REGISTRAR <u>12-31-61</u> 24b. REGISTRAR'S SIGNATURE <u>Chas E. Thomas</u>  |  |  |  |



15 (4)  
9/SB

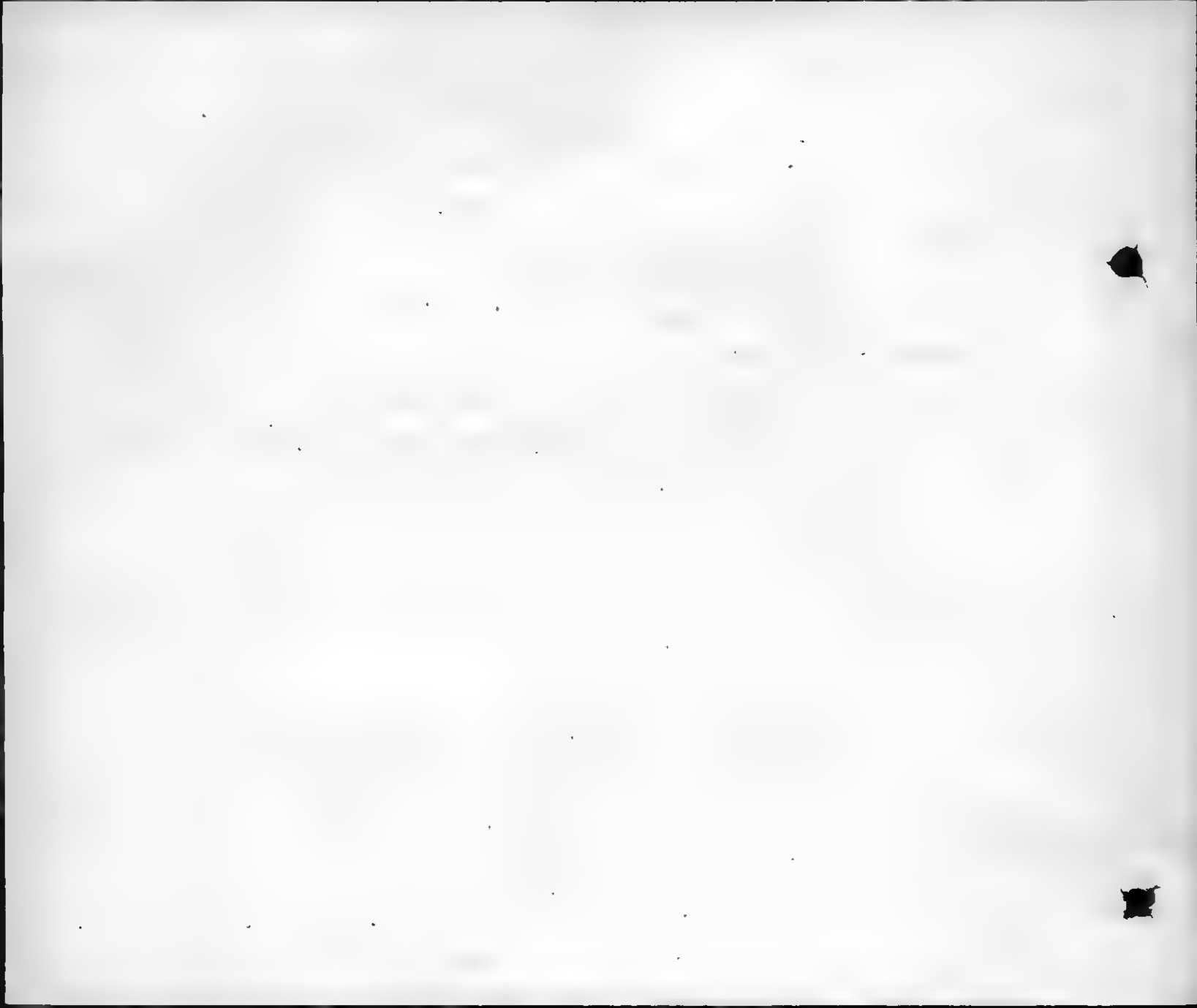
Item 2 File # 3305 1/8/62 mh  
**CERTIFICATE OF DEATH**

14114

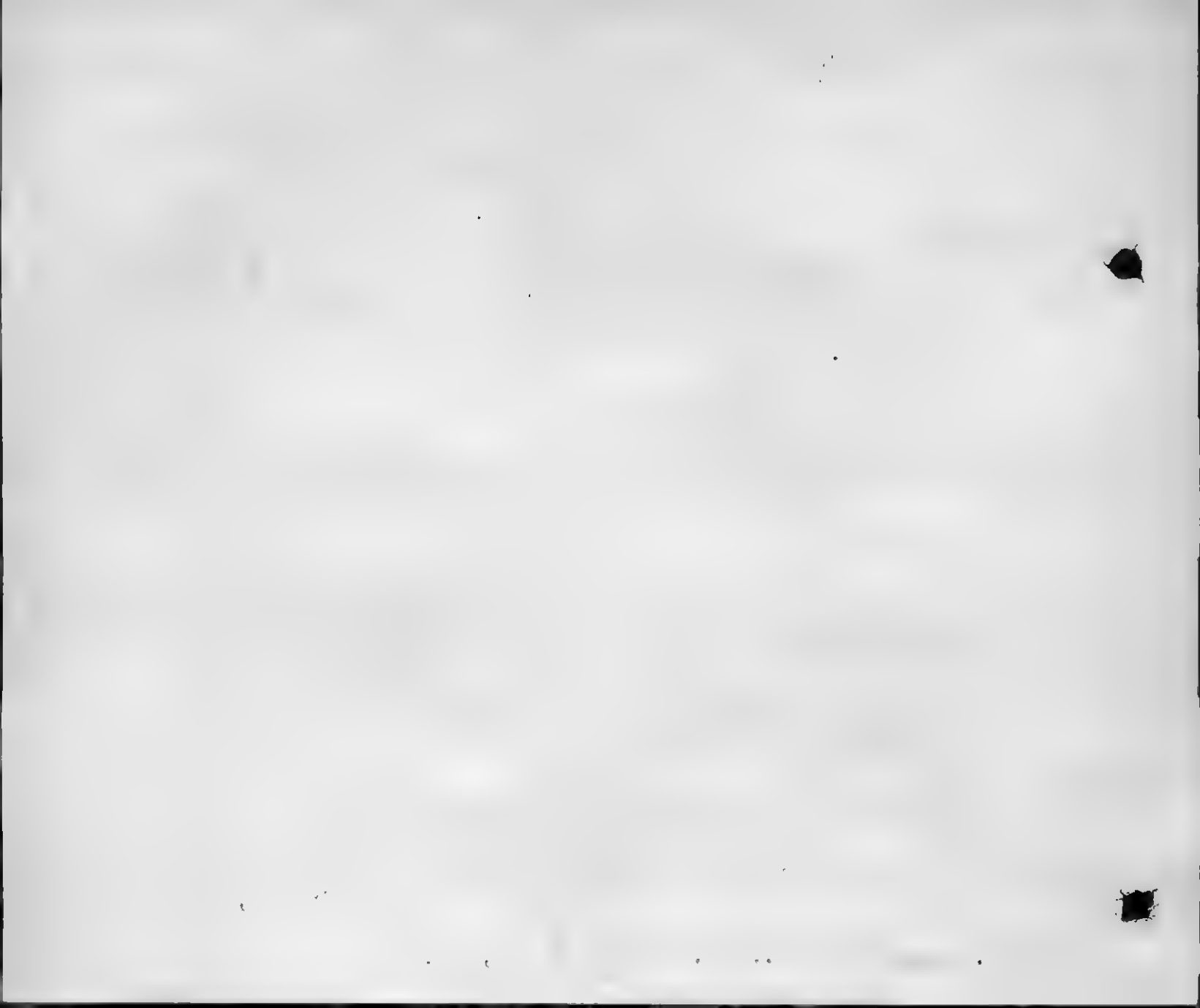
# CERTIFICATE OF DEATH

Reg. Dist. No. **44082**

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Bel Pre Sanitarium</b>  |                                  | e. STREET ADDRESS<br><b>5000 Aberdeen Rd.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>SIMON</b> Middle <b>GERBER</b> Last <b>GERBER</b>  |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>31</b> Year <b>1961</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Apr. 6, 1882</b>   |
| 9. AGE (In years last birthday)<br><b>79</b> yrs   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>   | 11. IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Pharmacist-Retired</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Pharmacist-Retired</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Russia</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Unknown</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |   |
| 17. INFORMANT<br><b>Maurice B. Miller Bethesda, Maryland</b>   |                                  | 18. 8000 Aberdeen Road   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |                                  |  |   |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>   |                                  |  |   |
| DUE TO (b) <b>Arteriosclerotic Heart Disease</b>   |                                  |  |   |
| DUE TO (c) <b>Arteriosclerotic Heart Disease</b>   |                                  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Arteriosclerosis</b>   |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>9/19</b> , 19 <b>61</b> , to <b>12/31</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>12/30</b> , 19 <b>61</b> , and that death occurred at <b>6:45</b> A.M., from the causes and on the date stated above. |                                  |  |   |
| ACTUAL SIGNATURE <b>Irving W. Winik</b>  |                                  | DATE SIGNED <b>12/31</b>   |   |
| PHYSICIAN'S NAME (Type) <b>Irving W. Winik</b>   |                                  | M.D. <b>3900 McKenley St. NW</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Jan. 2, 1962</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>King David Memorial Garden</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Falls Church, Va.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Bernard Danzansky &amp; Sons</b>  |                                  | 24. REC'D BY REGISTRAR<br><b>JAN 4 '62</b>   |   |
| 25. ADDRESS<br><b>3501 14th St. NW</b>   |                                  | 26. REGISTRAR'S SIGNATURE<br><b>C. L. S. Thomas</b>  |   |







# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14116

## CERTIFICATE OF DEATH

14084

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY (If not in hospital, give street address)

14 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sanitarium & Hosp.

### 2. USUAL RESIDENCE (Where deceased lived, if not last one; Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

d. STREET ADDRESS

704 Gilbert Street

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒

### 3. NAME OF DECEASED (Type or print)

Walter

William Gorton

### 4. DATE OF DEATH

December 5, 1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

December 5, 1909

9. AGE (In years, last birthday)

52 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Yard clerk

10b. KIND OF BUSINESS OR INDUSTRY

Wash. Sub. Sanitary

11. BIRTH-PLACE (County & State, or foreign country)

Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry R. Gorton

14. MOTHER'S MAIDEN NAME

Dora Simmons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No.

16. SOCIAL SECURITY NO.

Yes, on

17. INFORMANT

Washington Sanitarium and Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

Carcinoma of the lung & metastases

INTERVAL BETWEEN ONSET AND DEATH

5 wks.

163X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.

Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Dec 5, 1961, to Dec 15, 1961, that (I) (we) last saw the deceased alive on Dec 14, 1961, and that death occurred at 10 AM, from the causes and on the date stated above.

22a. SIGNATURE

Abraham W. Davis

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

12-15-61

22c. PHYSICIAN'S NAME (Type)

ABRAHAM W. DAVIS

22d. ADDRESS

1106 SPRING ST. Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL Dec. 18, 1961

23c. NAME OF CEMETERY OR CREMATORY

Rock Creek

23d. LOCATION (City, town or county)

Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE

W. W. Chambers Inc.

ADDRESS

8655 G & Ave Silver Spring Md

25a. REC'D BY REGISTRAR

DEC 18 '61

25b. REGISTRAR'S SIGNATURE

William S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and fully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



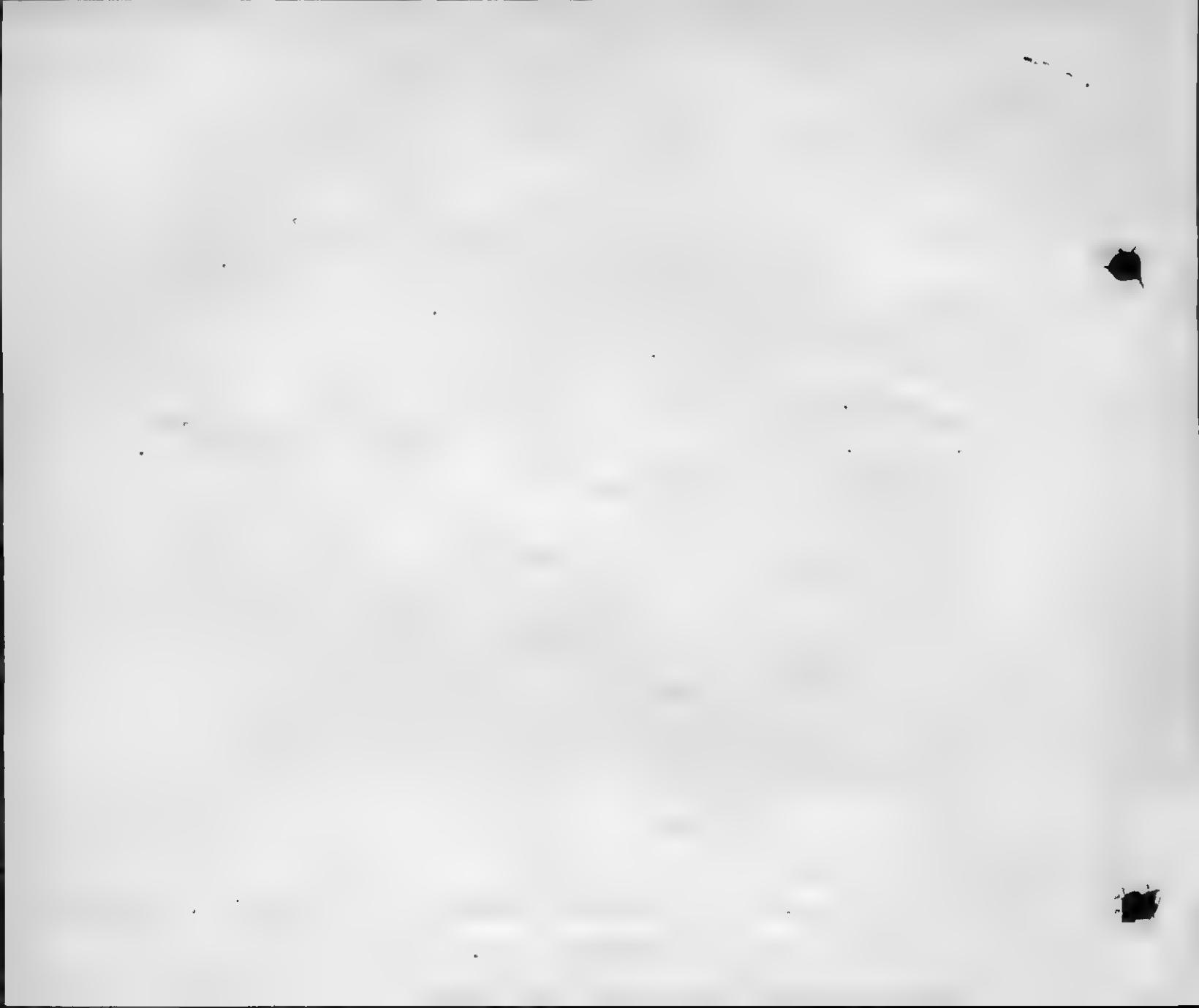


HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |  |  |  |  |  |  |
| 14117  |  |  |  |  |  | 14085  |  |  |  |  |  |
| 1. PLACE OF DEATH  |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  |  |  |  |  |  |
| a. COUNTY<br><b>Montgomery</b>   |  |  |  |  |  | a. STATE<br><b>Maryland</b>  |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |  |  |  |  |  | b. COUNTY<br><b>Montgomery</b>   |  |  |  |  |  |
| c. LENGTH OF STAY IN 1b<br><b>24 hrs</b>   |  |  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>35 Kensington</b>   |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Suburban</b>  |  |  |  |  |  | d. STREET ADDRESS<br><b>3822 Lawrence Ave,</b>   |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Bertha</b>  |  |  |  |  |  | 4. DATE OF DEATH<br><b>Dec. 24, 19 61</b>  |  |  |  |  |  |
| 5. SEX<br><b>Female</b>  |  |  |  |  |  | 6. COLOR OR RACE<br><b>White</b>   |  |  |  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  |  | 8. DATE OF BIRTH<br><b>Nov. 3, 1890</b>  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>James A. Gordon</b>  |  |  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>?</b>   |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)  |  |  |  |  |  | 16. SOCIAL SECURITY NO   |  |  |  |  |  |
| 17. INFORMANT<br><b>Melvin Roderick(son)</b>   |  |  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure &amp; shock</b><br>420.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic disease</b><br>(a), stating the underlying cause last, (c) <b>ser. yro.</b> |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)   |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Diabetes mellitus</b>   |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>12/24/1961</b>   |  |  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12/23, 1961</b> to <b>12/24, 1961</b> , that (I) (we) last saw the deceased alive on <b>12/24, 1961</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above. |  |  |  |  |  | 22a. SIGNATURE<br><b>Marvin Wadler</b>   |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>MARVIN WADLER</b>   |  |  |  |  |  | 22b. DATE SIGNED<br><b>DEC 28 '61</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  |  |  |  | 23b. DATE THEREOF<br><b>12-27-61</b>   |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Brownsville Cemetery</b>  |  |  |  |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Brownsville, Maryland</b>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>ROBERT A. PUMPHREY</b>  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>DEC 28 '61</b>   |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>C. S. S. Kline</b>  |  |  |  |  |  |  |  |  |  |  |  |



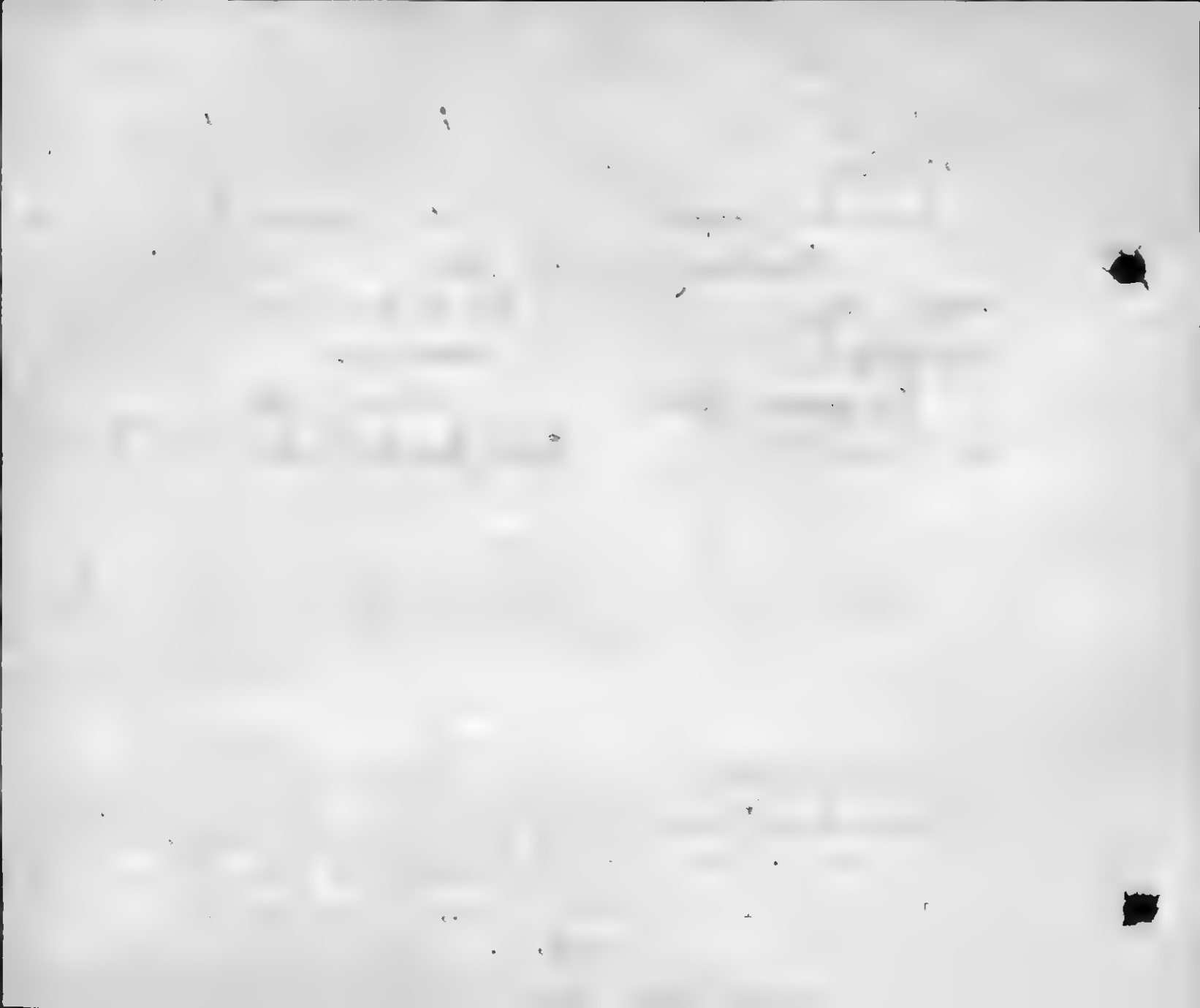
14118

CERTIFICATE OF DEATH

14086

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>  |   |
| c. LENGTH OF STAY IN 1b <u>6 1/2 hrs</u>  |  | d. STREET ADDRESS <u>1407 Wheaton Lane</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Clarence McKinley Green</u>  | 4. DATE OF DEATH<br>Month Day Year<br><u>Dec 19 1961</u>   |  |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>Negro</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Feb 10, 1917</u>                               |
| 9. AGE (In years last birthday) <u>44 yrs.</u>  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u> | 11. BIRTHPLACE (Country & State, or foreign country) <u>Maryland</u>   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                            |
| 13. FATHER'S NAME <u>Ferguson Green</u>   | 14. MOTHER'S NAME <u>Earline Wright</u>  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>World War II</u>   |   |
| 16. SOCIAL SECURITY NO. <u>4013 Pyles Miller</u>  |  | 17. INFORMANT <u>Estelle Jane Green (wife) - Kensington, Md.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Respiratory insufficiency</u><br>DUE TO (b) <u>Pulmonary Edema</u><br>DUE TO (c) <u>Mucoid obstruction of Bronchi</u>   |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 hour?</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)   |  |  |   |
| 18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 19a. TIME OF INJURY<br>Hour e.m. p.m.<br><u>19</u>  | 19b. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>    | 19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 19d. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/18/61</u> , 19 <u>61</u> , to <u>12/19/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/19/61</u> , 19 <u>61</u> , and that death occurred at <u>12:00 AM</u> , from the causes and on the date stated above. |  |  |   |
| 22a. SIGNATURE<br><u>Edward S. Witowski, Jr.</u>  |  | 22b. DATE SIGNED<br><u>12/20/61</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>Edward S. Witowski, Jr.</u>   |  | 22d. ADDRESS<br><u>SUITE 400, 8218 WISCONSIN AVE. BETHESDA 14, MD.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF<br><u>12/26/61</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Arlington National</u>  | 23d. LOCATION (City, town or county) (State)<br><u>Arlington, Va.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert H. Brander</u>  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 29 '61</u>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Robert S. Finner</u>   |  |  |   |

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14119

14087

|   |   |  |   |
|---|---|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u><br>c. LENGTH OF STAY IN 1b <u>53 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery General Hospital</u> |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg, X</u><br>d. STREET ADDRESS <u>Rt. Box 226</u><br>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Francis Charles Green</u><br>First Middle Last   |   | <b>4. DATE OF DEATH</b><br>Month <u>12</u> Day <u>2</u> Year <u>19 61</u>  |   |
| <b>5. SEX</b><br><u>male</u>  | <b>6. COLOR OR RACE</b><br><u>white</u> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | <b>8. DATE OF BIRTH</b><br><u>1/28/1889</u> |
| <b>9. AGE</b> (In years last birthday) <u>72</u> yrs.   |   | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>farmer</u>  |   |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>  |   | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>   |   |
| <b>13. FATHER'S NAME</b><br><u>Irvin Green</u>  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Harriett Lafsnider</u>   |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)   |   | <b>16. SOCIAL SECURITY NO.</b>   |   |
| <b>17. INFORMANT</b><br><u>Hospital Records</u>   |   | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for a, b, and c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u><br>DUE TO (b) <u>CORONARY ARTERIOSCLEROSIS</u><br>DUE TO (c) <u>Diabetes Mellitus</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)              |   |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | <b>20. TIME OF INJURY</b> Month, Day, Year<br>Hour e.m. p.m. <u>19</u>   |   |
| <b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>10-10-1961</u> to <u>12-2-1961</u> , that (I) (we) last saw the deceased alive on <u>12-2-1961</u> , and that death occurred at <u>6 p.m.</u> from the causes and on the date stated above.   |   | <b>22. SIGNATURE</b><br><u>Jack Schumacher</u> M.D.<br><b>22c. PHYSICIAN'S NAME</b> (Type) <u>Jack Schumacher</u>  |   |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>   |   | <b>23b. DATE THEREOF</b> <u>12-4-61</u>  |   |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Ernest C. Gartner</u>   |   | <b>25. REC'D BY REGISTRAR</b> <u>Gaithersburg, Md.</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ACUTE MYELOID LEUKEMIA  
CHRONIC MYELOID LEUKEMIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and duly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14120

14088

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Suburban Hospital

### 3. NAME OF DECEASED

(Type or print)

James Edward

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Dec. 13 1961

### 4. DATE OF DEATH

Month

Day

Year

Dec 13 1961

9. AGE (In years last birthday)

3

50

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John William

(Unknown)

Greene

14. MOTHER'S MAIDEN NAME

Nattalie Patricia Griffith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO. (If yes give war dates of service)

17. INFORMANT

Address

(Hospital Record.)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

76

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Respiratory failure

Subarachnoidal hemorrhage

Birth trauma

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 13 Dec 1961 to 13 Dec 1961, that (I) (we) last saw the deceased alive on 13 Dec 1961, and that death occurred at 12:00 PM from the causes and on the date stated above.

22a. SIGNATURE

RH Mitchell

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

18 Dec 61

22c. PHYSICIAN'S NAME (Type)

RH MITCHELL MD

22d. ADDRESS

8218 Wisconsin Ave Bethesda Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

12-26-61

23c. NAME OF CEMETERY OR CREMATORY

Parklawn Cemetery

23d. LOCATION (City, town or county)

Rockville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Robert A. Pumphrey, Bethesda, Md.

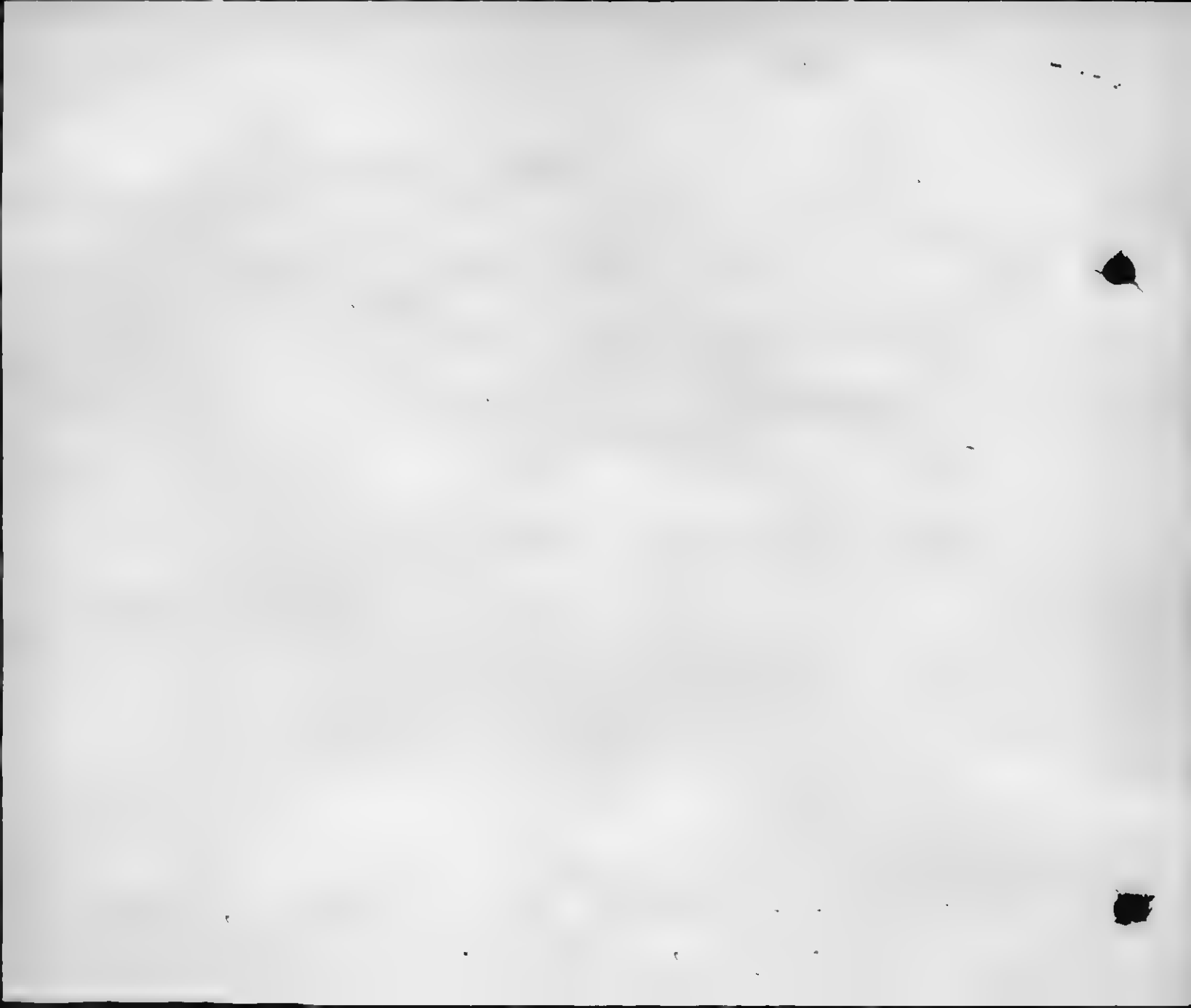
25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DEC 28 '61

Arthur L. Kinn

2074404x

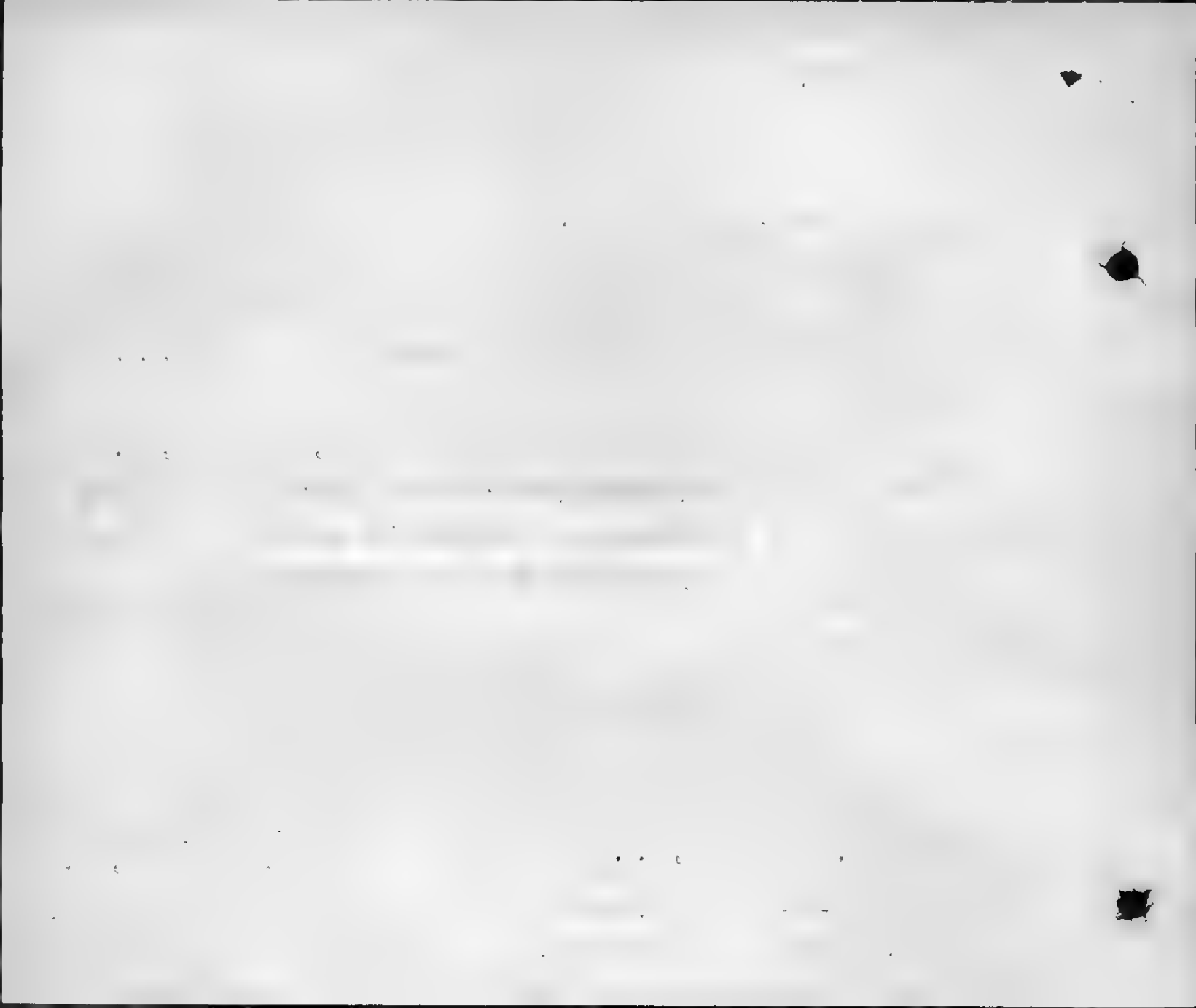




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                           |  |  |  |                                  |  |   |  |   |  |
|---|--|---------------------------|--|--|--|----------------------------------|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                           |  |  |  |                                  |  |   |  |   |  |
| CERTIFICATE OF DEATH  |  |                           |  |  |  |                                  |  |   |  |   |  |
| 14121   |  |                           |  |  |  |                                  |  |   |  |   |  |
| 14089   |  |                           |  |  |  |                                  |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery  |  |                           |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>Maryland<br>b. COUNTY<br>Montgomery                 |  |                                  |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda  |  |                           |  | c. LENGTH OF STAY IN 1b<br>9 days  |  |                                  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Kensington    |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>The Clinical Center, Bethesda 14, Md.   |  |                           |  | d. STREET ADDRESS<br>4821 Flanders Avenue  |  |                                  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>Victoria (No middle name) Gruver  |  |                           |  | 4. DATE OF DEATH<br>December 24 19 61  |  |                                  |  |   |  |   |  |
| 5. SEX<br>Female  |  | 6. COLOR OR RACE<br>White |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>5 April 1894 |  | 9. AGE (In years last birthday)<br>67 yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Seamstress   |  |                           |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Self employed   |  |                                  |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Pennsylvania                               |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.    |  |
| 13. FATHER'S NAME<br>Daniel Gruver  |  |                           |  | 14. MOTHER'S MAIDEN NAME<br>Katherine Schnee   |  |                                  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br>No  |  |                           |  | 16. SOCIAL SECURITY NO.<br>Not available   |  |                                  |  | 17. INFORMANT<br>The Medical Record<br>The Clinical Center, Bethesda 14, Md.                      |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                           |  |  |  |                                  |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1964 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) CARDIORESPIRATORY ARREST<br>(c) OSTEOREGIC SARCOMA WITH<br>causing the underlying disease last. PULMONARY METASTASIS            |  |                           |  |  |  |                                  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 MIN<br>INTERVAL BETWEEN ONSET AND DEATH<br>6 MONTHS   |  |                           |  |  |  |                                  |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                           |  |  |  |                                  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                           |  |  |  |                                  |  |   |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |                           |  |  |  |                                  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |  |                           |  |  |  |                                  |  |   |  |   |  |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |  |                           |  |  |  |                                  |  |   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |                           |  |  |  |                                  |  |   |  |   |  |
| 20f. (City or town) (County) (State)  |  |                           |  |  |  |                                  |  |   |  |   |  |
| 21. I certify that (X) (this hospital) attended the deceased from December 15, 1961, to December 24, 1961, that (X) (we) last saw the deceased alive on December 24, 1961, and that death occurred at 7:15 P.M. from the causes and on the date stated above. |  |                           |  |  |  |                                  |  |   |  |   |  |
| 22a. SIGNATURE<br>J. Kent Trinkle, M.D.   |  |                           |  |  |  |                                  |  |   |  |   |  |
| 22b. DATE<br>December 25, 1961  |  |                           |  |  |  |                                  |  |   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br>J. Kent Trinkle, M.D.   |  |                           |  |  |  |                                  |  |   |  |   |  |
| 22d. ADDRESS<br>The Clinical Center, National Institutes of Health, Bethesda 14, Md.  |  |                           |  |  |  |                                  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial-transit   |  |                           |  |  |  |                                  |  |   |  |   |  |
| 23b. DATE THEREOF<br>12-25-61   |  |                           |  |  |  |                                  |  |   |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>St. Mary's Cemetery   |  |                           |  |  |  |                                  |  |   |  |   |  |
| 23d. LOCATION (City, town or county) (State)<br>Hanover Township, Penna.  |  |                           |  |  |  |                                  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>Robert A. Pumphrey  |  |                           |  |  |  |                                  |  |   |  |   |  |
| 25a. REC'D BY REGISTRAR<br>DATE DEC 28 '61  |  |                           |  |  |  |                                  |  |   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br>Arthur S. Kraus   |  |                           |  |  |  |                                  |  |   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

|  |   |   |                                      |
|--|---|---|--------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   | INTERVAL BETWEEN ONSET AND DEATH  |                                      |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>broncho pneumonia</u><br>1655 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>premature</u><br>(a), stating the underlying cause last, DUE TO (c)   |   |   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) |                                      |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m. <u>10</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                      | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/6</u> 19 <u>61</u> , to <u>12/7</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/7 8:30 PM</u> 19 <u>61</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above. |   |   |                                      |
| 22a. SIGNATURE<br><u>Vita R. Jaffe</u>   |   | 22b. DATE SIGNED<br><u>12/7/61</u>  |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JAFFE, Vita R</u>   |   | 22d. ADDRESS<br><u>5079 Brady Blvd Chelmsbury</u>   |                                      |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF<br>REMOVAL (Specify)<br><u>CREMATION 12-8-61</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>SUBURBAN HOSPITAL</u>                              |                                      |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>AMELIA C. CARTER ADMIN. - SUBURBAN HOSPITAL</u><br>(Spec F (B))   |   | 25a. REC'D BY REGISTRAR<br><u>DEC 12 '61</u>  |                                      |
| 25b. REGISTRAR'S SIGNATURE<br><u>W. S. Thorne</u>  |   |   |                                      |

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN b <u>3</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Suburban Hospital</u> |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u><br>d. STREET ADDRESS <u>1231 Gladstone Dr</u> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>LISA MARIE GUARDINO</u>  |  | 4. DATE OF DEATH<br>Month Day Year<br><u>December 7 1961</u>   |  |
| 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>DEC 6, 1961</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.<br><u>1 - - 25</u>  |  |
| 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>  |  |
| 13. FATHER'S NAME <u>JOSEPH JOHN GUARDINO</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  | 14. MOTHER'S MAIDEN NAME <u>MARLEEN AGNES CLARK</u><br><u>MOTHER</u>   |  |
| 17. INFORMANT <u>MOTHER</u>   |  | Address  |  |

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# CERTIFICATE OF DEATH

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14123

Item 21 Film G303 12/21/61 iwk

Chittam P. Kumar

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The funeral director must file this certificate with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14124

14093

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| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b <u>41 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u> |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, Residence before admission)<br>a. STATE <u>Pennsylvania</u><br>b. COUNTY <u>Cumberland</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shippensburg</u><br>d. STREET ADDRESS <u>Star Route 2</u>   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Walter Stewart Hall</u>   |  | <b>4. DATE OF DEATH</b><br>Month <u>December</u> Day <u>11</u> Year <u>1961</u>  |  |
| <b>5. SEX</b> <u>Male</u><br><b>6. COLOR OR RACE</b> <u>White</u><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b> <u>November 1, 1899</u><br><b>9. AGE</b> (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pennsylvania</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>                 |  | <b>13. FATHER'S NAME</b> <u>William Hall</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Gertrude Winters</u>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u><br><b>16. SOCIAL SECURITY NO.</b> <u>Unascertainable</u><br><b>17. INFORMANT</b> <u>The Medical Record</u>  |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Probable clostridial septicemia</u><br>04 } DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gas gangrene of scrotum and perineum</u><br>DUE TO (c) <u>Chronic lymphocytic leukemia</u> |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>? 6-8 hours</u><br><u>? 1 Day</u><br><u>6 Months</u>  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)  |  |
| <b>21. I certify that</b> <u>H</u> (This hospital) attended the deceased from <u>October 31, 1961</u> , to <u>December 11, 1961</u> that <u>I</u> (we) last saw the deceased alive on <u>December 11, 1961</u> , and that death occurred at <u>12:00 PM</u> from the causes and on the date stated above.                          |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Edward S. Henderson</u><br><b>22b. PHYSICIAN'S NAME</b> (Type) <u>Edward S. Henderson M.D.</u>   |  | <b>22c. ADDRESS</b><br><u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial-Transit 12/12/61</u>  |  | <b>23b. DATE THEREOF</b> <u>12/12/61</u>   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Spring Hill Cemetery</u>  |  | <b>23d. LOCATION</b> (City, town or county) (State) <u>Shippensburg, Penna.</u>  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Robert A. Pumphrey, Bethesda, Maryland</u>   |  | <b>25a. REC'D BY REGISTRAR</b> <u>DEC 15 '61</u><br><b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thorne</u>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 23b, Film G305 1/10/62 iwk

14094

|   |  |  |  |   |  |   |  |   |  |   |  |  |  |   |  |   |  |         |  |
|---|--|--|--|---|--|---|--|---|--|---|--|--|--|---|--|---|--|---------|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery  |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Rural - Bethesda |  | c. LENGTH OF STAY in lb<br>1 Day  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before adm ssion)<br>a. STATE<br>District of Columbia b. COUNTY |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Washington  |  | d. STREET ADDRESS<br>2015 Newton St., N.E.                              |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  |   |  |   |  |         |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>Timothy Allen Hamilton   |  | 4. DATE OF DEATH<br>Month Day Year<br>December 18 19 61  |  | 5. SEX<br>Male  |  | 6. COLOR OR RACE<br>Negro   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>17 December 1961                                    |  | 9. AGE (in years last birthday)<br>yrs. Months Days<br>8 7   |  | 10. IF UNDER 1 YEAR<br>Months Days<br>8 7   |  | 11. IF UNDER 24 HRS.<br>Hours Min.<br>8 7           |  |         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Montgomery, Maryland |  | 12. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 13. FATHER'S NAME<br>George Hamilton  |  | 14. MOTHER'S MAIDEN NAME<br>Evelyn Hamilton                             |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br>No |  | 16. SOCIAL SECURITY NO.<br>-  |  | 17. INFORMANT<br>Hospital Records                   |  | Address |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>PREMATURITY</b><br>771X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. } DUE TO<br>c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour e.m. p.m. 19<br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) County State |  |  |  |   |  |   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |         |  |
| 21. I certify that (this hospital) attended the deceased from Dec. 17, 1961, to Dec. 18, 1961, that (I) (we) last saw the deceased alive on Dec. 18, 1961, and that death occurred at 3:10 AM from the causes and on the date stated above.   |  |  |  |   |  |   |  |   |  |   |  | 22a. SIGNATURE<br>Bernard H. Feldman M.D.<br>22c. PHYSICIAN'S NAME (Type)<br>BERNARD H. FELDMAN LT MC USN      |  | 22b. DATE SIGNED<br>December 19, 1961   |  | 22d. ADDRESS<br>U. S. Naval Hospital, Bethesda, Md. |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF<br>12/22/61  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National                    |  | 23d. LOCATION (City, town or county)<br>Arlington, Virginia   |  | 23e. (State)  |  | 24. FUNERAL DIRECTOR'S SIGNATURE<br>John T. ...<br>24b. ADDRESS<br>D.C. |  | 25a. REC'D BY REGISTRAR<br>DEC 26 '61  |  | 25b. REGISTRAR'S SIGNATURE<br>C. ...  |  |   |  |         |  |

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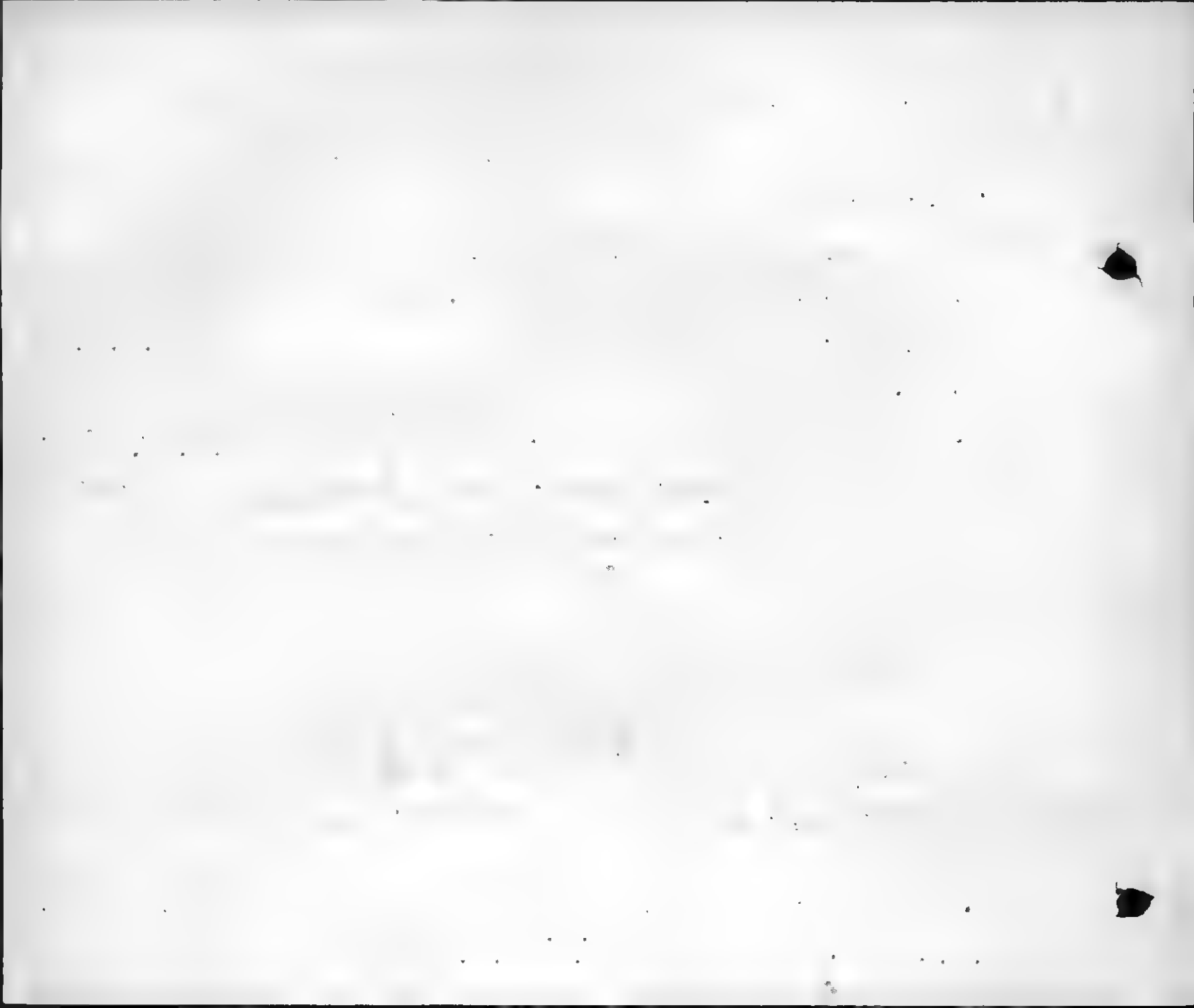


## CERTIFICATE OF DEATH

Reg. Dist. No. 14095

14126

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|--|----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. <b>Montgomery Silver Spring MARYLAND</b>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>   |                                  | c. LENGTH OF STAY IN 1b   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>24 Silver Springs</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>762 Silver Spring Ave</b>  |                                  |   | d. STREET ADDRESS<br><b>762 Silver Springs Ave</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Harry</b> Middle <b>J</b> Last <b>Hayden</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>4</b> Year <b>19 61</b>  |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 19, 1874</b>   |  | 9. AGE (In years last birthday) <b>87</b> yrs.<br>IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Civil Service</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Government</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>OHIO</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                  |   | 13. FATHER'S NAME<br><b>Elisha K Hayden</b>   |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Margaret Williams</b>   |                                  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)                         |  |  |
| 16. SOCIAL SECURITY NO<br><b>INFORMANT Daughter</b>  |                                  |   | Address<br><b>Mrs. Eva May Garrison 762 Silver Springs Ave S. S. Md.</b>  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |                                  |   |   |  |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular Thrombosis</b>  |                                  |   |   |  |  |
| 332X DUE TO  |                                  |   |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO   |                                  |   |   |  |  |
| (c)  |                                  |   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |   |  |  |
| 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                       |  |
| 20f. (City or town)  |                                  | (County)  |   | (State)  |  |
| 21. I certify that I attended the deceased from <b>April</b> , 19 <b>61</b> , to <b>Dec</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Dec 3</b> , 19 <b>61</b> , and that death occurred at <b>5:59 AM</b> , from the causes and on the date stated above. |                                  |   |   |  |  |
| ACTUAL SIGNATURE<br><b>Robert S. Poole</b>   |                                  | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>4501 Conn. Ave. N.W. 12/4/61</b>  |   |  |  |
| PHYSICIAN'S NAME (Type)<br><b>Washington, D. C.</b>  |                                  |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>12/6/61</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem</b>  |  |
| 22d. LOCATION (City, town, or county) (State)<br><b>Prince Georges County Maryland</b>   |                                  | 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Washington, D. C.</b>  |   |  |  |
| 24a. REC'D BY REGISTRAR<br><b>DEC 6 '61</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |   |  |  |



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FOR STATE  
HEALTH DEPT.

any delay is necessary, the funeral director, Page 5 may be retained for your files. The State Board of Health, in any event, within 72 hours after death.

| <div> <div>14127</div> <div>14096</div> </div> <div> <div>1</div> <div>VS. A15ME</div> <div>5M 9/60</div> </div>  |  |   |  |  |  |   |  |   |  |  |  |
|---|--|---|--|--|--|---|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN b. <u>1 day-9hrs</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>d. STREET ADDRESS <u>4616 Sleaford Road</u>                   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                  |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Pauline E. Hellback</u>  |  |   |  | <b>4. DATE OF DEATH</b><br>Month <u>Dec.</u> Day <u>23</u> Year <u>19 61</u>   |  |   |  |   |  |  |  |
| <b>5. SEX</b><br><u>Female</u>  |  | <b>6. COLOR OR RACE</b><br><u>White</u> |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br><u>Feb. 28, 1883</u>   |  | <b>9. AGE</b> (In years last birthday) <u>78</u> yrs. <div>             IF UNDER 1 YEAR: Months <u>23</u> Days <u>25</u> </div> |  | <b>10. IF UNDER 24 HRS</b><br>Hours <u>14</u> Min. <u>00</u> |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>   |  |   |  | <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>            |  |
| <b>13. FATHER'S NAME</b><br><u>Robert Zorn</u>  |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Augusta Winkelman</u>  |  |   |  |   |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>—</u>   |  |   |  | <b>16. SOCIAL SECURITY NO.</b> <u>—</u>  |  |   |  | <b>17. INFORMANT</b><br><u>(Paula Fowler) daughter</u>  |  |  |  |
|   |  |   |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) <div> <b>PART I. DEATH WAS CAUSED BY:</b><br/>             IMMEDIATE CAUSE (a) <u>Cerebral Edema</u><br/>             (b) <u>Cardiorespiratory Failure</u><br/>             (c) <u>Pulmonary Insufficiency - Metastatic Carcinoma</u> </div> |  |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>8 hours</u><br><u>unknown</u>   |  |  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b><br><u>14 hours Status Postoperative - Nailing Rt Femur</u>  |  |   |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/></b>  |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18)<br><u>Fell on floor at home - Fracture rt hip</u>   |  |   |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br><u>2:00 p.m. 12-21 1961</u>  |  |   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>home</u> |  | <b>20f. (City or town)</b> <u>Bethesda</u>  |  | <b>(County)</b> <u>montg</u> <b>(State)</b> <u>md</u>        |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</b> <div>           Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> </div> |  |   |  |  |  |   |  |   |  |  |  |
| <b>ACTUAL SIGNATURE</b> <u>Frank J. Brosch</u>  |  |   |  | <b>M.D. ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>  |  |   |  | <b>DATE SIGNED</b> <u>12-23-61</u>  |  |  |  |
| <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. BROSCHE</u>   |  |   |  | <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>   |  |   |  |   |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>  |  |   |  | <b>22b. DATE THEREOF</b> <u>Dec. 26, 1961</u>  |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u>                        |  | <b>22d. LOCATION (City, town, or country)</b> <u>Rockville</u>  |  | <b>(State)</b> <u>Md.</u>                                    |  |
| <b>23. FUNERAL DIRECTOR</b><br><u>Raymond A. Ziska</u><br><u>Warner E. Pumphrey, Inc.</u>   |  |   |  | <b>ADDRESS</b><br><u>8434 Georgia Ave.,</u><br><u>Silver Spring, Md.</u>   |  |   |  | <b>24a. REC'D BY REGISTRAR</b> <u>DEC 28 '61</u>  |  | <b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Kline</u>    |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14128

14097

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Clarksburg - RFD</u><br>c. LENGTH OF STAY IN IL <u>10 yrs</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montg.</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg - RFD</u><br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>Edward</u> Middle <u>Ostorne</u> Last <u>Henderson</u>  |  | <b>4. DATE OF DEATH</b><br>Month <u>Dec</u> Day <u>10</u> Year <u>1961</u>   |  |
| <b>5. SEX</b> <u>M</u><br><b>6. COLOR OR RACE</b> <u>W.</u><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>8. DATE OF BIRTH</b> <u>March 5 - 1876</u><br><b>9. AGE</b> (In years last birthday) <u>85</u> yrs.<br><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farm. laborer</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>US</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> |  | <b>13. FATHER'S NAME</b> <u>Edward C. Henderson</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Suzanne E. Thompson</u><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)<br><b>16. SOCIAL SECURITY NO.</b><br><b>17. INFORMANT</b> <u>Mrs. Leo Clagett, Clarksburg-Md RFD</u><br>Address  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic heart disease</u><br>(c)  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Hours</u><br><u>Years</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Prostate Metastasis</u>  |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)   |  | <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |  |
| <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State)   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb. 1957</u> <b>to</b> <u>12-10-1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Sept. 14, 1961</u> , <b>and that death occurred at</b> <u>10:00 A.M.</u> <b>from the causes and on the date stated above.</b>   |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Jack Schumacher</u><br><b>22c. PHYSICIAN'S NAME (Type)</b> <u>JACK SCHUMACHER</u>  |  | <b>22b. DATE SIGNED</b> <u>12-11-61</u><br><b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/><br><b>22d. ADDRESS</b> <u>GAITHERSBURG M.D.</u>  |  |
| <b>23a. BURIAL, CREMATION REMOVAL (Specify)</b> <u>Burial</u><br><b>23b. DATE THEREOF</b> <u>12/12/61</u><br><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Mary's</u><br><b>23d. LOCATION (City, town or county)</b> <u>Rockville, Md</u> (State)   |  | <b>25a. REC'D BY REGISTRAR</b> <u>DEC 18 '61</u><br><b>25b. REGISTRAR'S SIGNATURE</b> <u>C. Stuart S. Thomas</u>   |  |

72. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

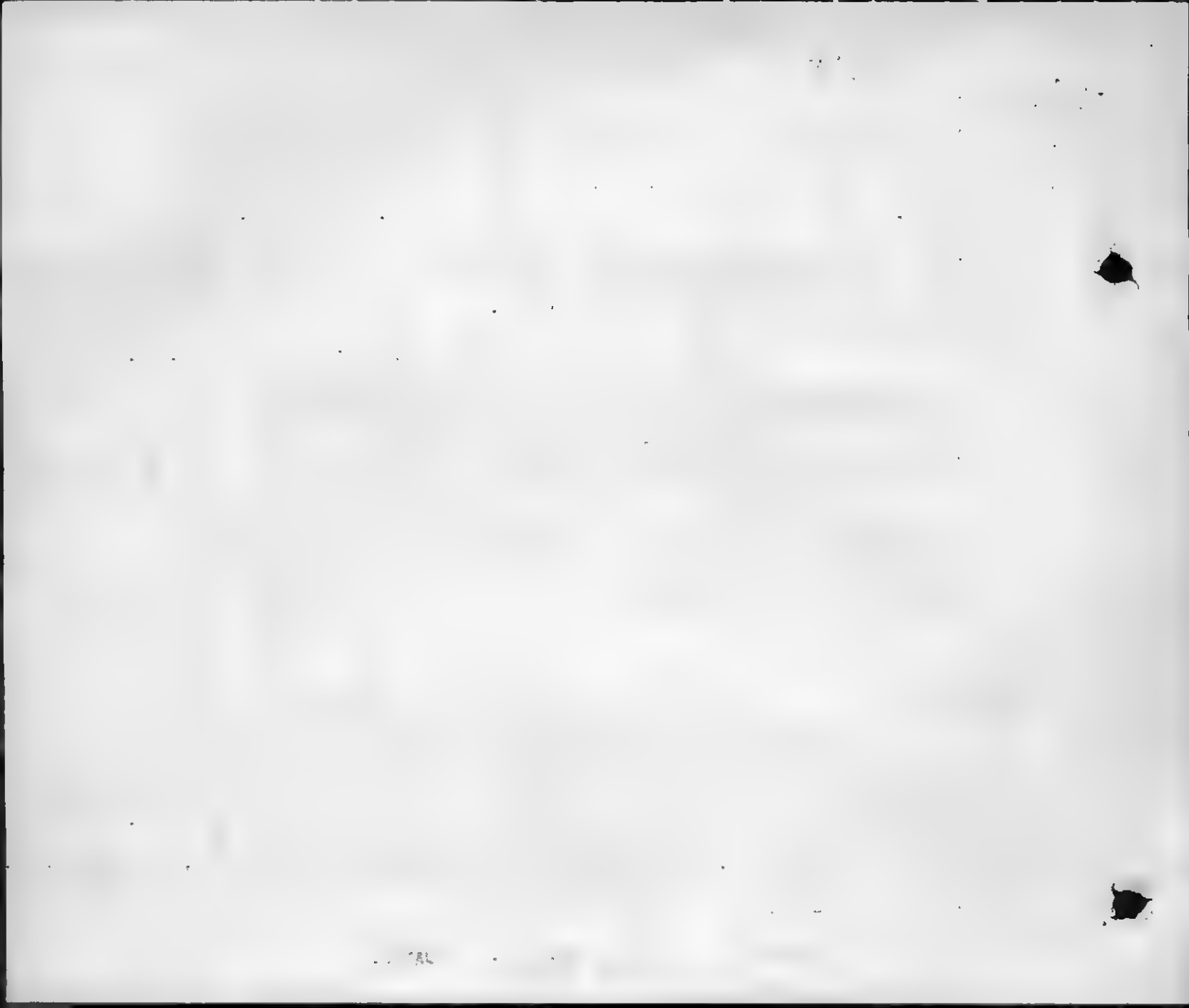
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14129

## CERTIFICATE OF DEATH

14098

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rockville</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>123 S. Adams Street</b>   |                                  | d. STREET ADDRESS<br><b>123 S. Adams Street</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>LAVINIA DAWSON HENDERSON</b>   |                                  | 4. DATE OF DEATH<br><b>Dec. 28, 1961</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 1, 1890</b> |
| 9. AGE (In years last birthday) <b>71</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>27</b> Hours <b></b> Min. <b></b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Rockville, Maryland</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>U. S.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S.</b>  |   |
| 13. FATHER'S NAME<br><b>Thomas Dawson</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Alice Peter</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                                  | 16. SOCIAL SECURITY NO. <b>215-38-3122B</b>  |   |
| 17. INFORMANT<br><b>Son</b>  |                                  | Address<br><b>Joseph Henderson Same as #2.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>coronary insufficiency</b><br>(c) <b>arteriosclerotic cardiovascular disease</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <b>None</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 min</b><br><b>5 years</b><br><b>5 years</b>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>a.m.</b> <b>19</b> p.m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 25, 1957</b> to <b>Dec. 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 23, 1961</b> , and that death occurred at <b>7:31 A.M.</b> , from the causes and on the date stated above.   |                                  |  |   |
| 22a. SIGNATURE<br><b>Stephen C. Cromwell</b> M.D.  |                                  | 22b. DATE SIGNED<br><b>Dec. 28, 1961</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>STEPHEN C. CROMWELL, JR.</b>  |                                  | 22d. ADDRESS<br><b>615 W. Montgomery Ave, Rockville, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>12-30-61</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rockville Cemetery</b>  |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Rockville, Maryland</b>   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>ROBERT A. PUMPHREY</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>JAN 2 '62</b>  |   |
| ADDRESS<br><b>Bethesda, Md.</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>C. S. Hanna</b>   |   |

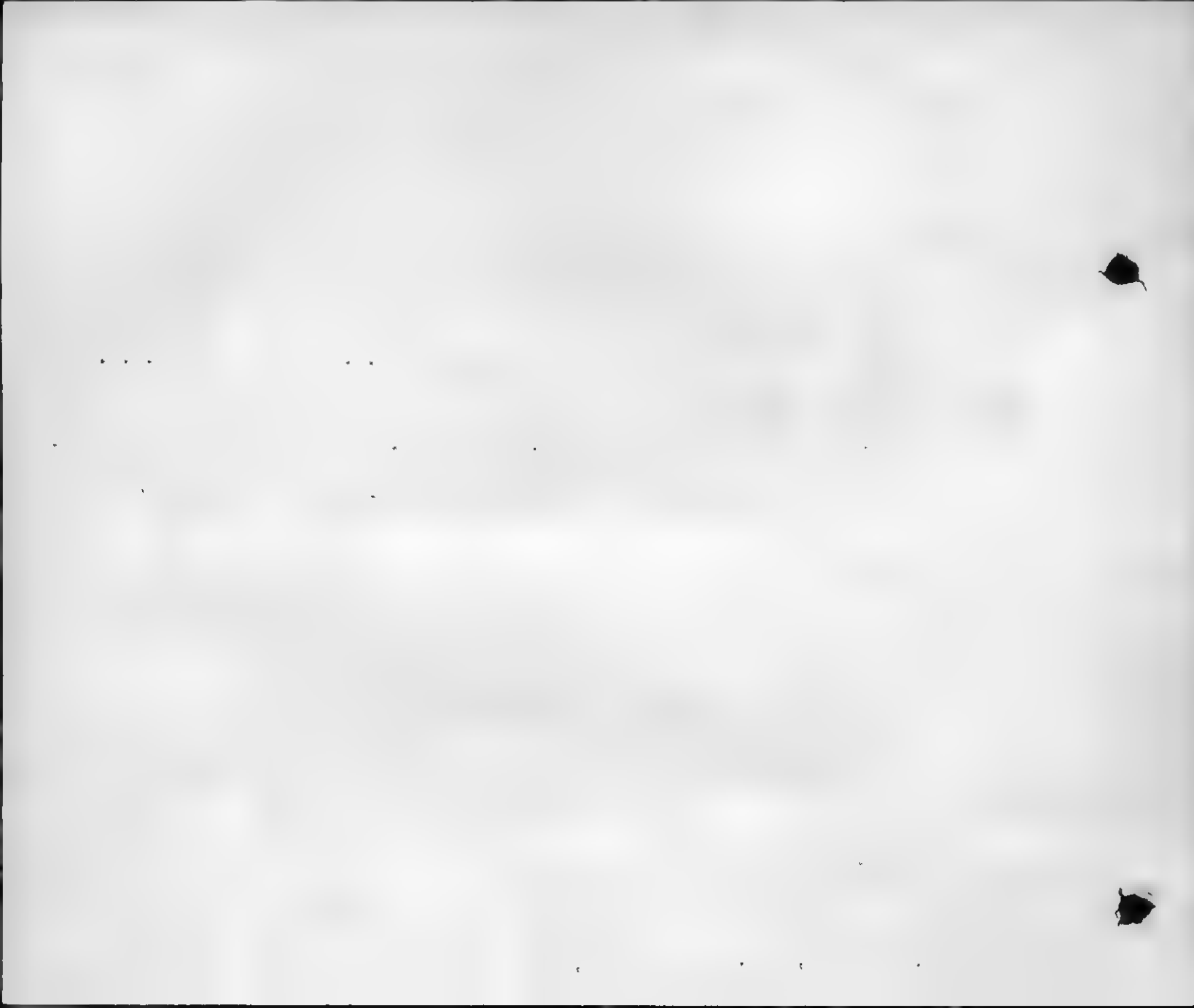


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. 1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b><br/> <b>CERTIFICATE OF DEATH</b> </div>  |                  |  |  |  |  |   |  |  |  |   |                  |   |      |  |  |   |  |  |  |
|--|------------------|--|--|--|--|---|--|--|--|---|------------------|---|------|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San &amp; Hosp.</u>  |                  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>STATE <u>Md.</u> COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>503 Stirling Rd.</u>  |  |   |  | <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Stanley S. Henderson</u>  |  |   |                  | <b>4. DATE OF DEATH</b><br>Year <u>1961</u> Month <u>12</u> Day <u>11</u> |      |  |  |   |  |  |  |
| <b>5. SEX</b><br><u>M</u>  |                  | <b>6. COLOR OR RACE</b><br><u>W</u>  |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br><u>2-23-02</u>                             |  | <b>9. AGE</b> (In years last birthday) <u>59</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> </table> |  | IF UNDER 1 YEAR   | IF UNDER 24 HRS. | Months  | Days | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Chemist</u> |  | <b>11. BIRTHPLACE</b> (Country & State or foreign country) <u>Washington D.C.</u> |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u> |  |
| IF UNDER 1 YEAR  | IF UNDER 24 HRS. |  |  |  |  |   |  |  |  |   |                  |   |      |  |  |   |  |  |  |
| Months   | Days             |  |  |  |  |   |  |  |  |   |                  |   |      |  |  |   |  |  |  |
| <b>13. FATHER'S NAME</b><br><u>Franklin Edward Henderson</u>   |                  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Jenny Fones</u>  |  |   |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>   |  |   |                  | <b>16. SOCIAL SECURITY NO.</b> <u>None</u>                                |      |  |  |   |  |  |  |
| <b>17. INFORMANT</b><br><u>Mrs. Margaret S. Henderson</u>  |                  |  |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>Conditions, if any, which gave rise to immediate cause (b) <u>420</u><br>(c) <u>420</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> |  |   |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |                  |   |      |  |  |   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>   |                  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)   |  |   |  |  |  |   |                  |   |      |  |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Hour <u>9</u> a.m. p.m.  |                  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b>  |  | <b>(County)</b>  |  | <b>(State)</b>  |                  |   |      |  |  |   |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1955</u> <b>to</b> <u>Dec. 11</u> , 19 <u>61</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Dec. 11</u> , 19 <u>61</u> , <b>and that death occurred at</b> <u>8:45</u> P.M. <b>from the causes and on the date stated above.</b> |                  |  |  |  |  |   |  |  |  |   |                  |   |      |  |  |   |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Raymond Bradshaw</u>   |                  |  |  | <b>22b. DATE SIGNED</b><br><u>12/11/61</u>   |  |   |  | <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>Raymond Bradshaw</u>   |  |   |                  |   |      |  |  |   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>  |                  |  |  | <b>23b. DATE THEREOF</b><br><u>12/15/61</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Parklawn Cemetery</u> |  | <b>23d. LOCATION (City, town or county)</b><br><u>Montgomery Maryland</u>  |  |   |                  |   |      |  |  |   |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Warner E. Humphrey, Inc.</u>   |                  |  |  | <b>24b. ADDRESS</b><br><u>8434 Georgia Avenue Silver Spring, Maryland</u>  |  |   |  | <b>25a. REC'D BY REGISTRAR</b><br><u>DEC 15 '61</u>  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>L. S. Kline</u> |                  |   |      |  |  |   |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |  |   |  |  |  |
|---|--|--|---|--|--|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |   |  |  |  |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |  |   |  |  |  |
| 14131   |  |  |   |  |  |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>Virginia   |  |  |  |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda  |  |  | b. COUNTY<br>Warren   |  |  |  |   |  |  |  |
| c. LENGTH OF STAY in TB<br>27 days  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Front Royal   |  |  |  |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>The Clinical Center, Bethesda 14, Md.   |  |  | d. STREET ADDRESS<br>13 Cherrywood Apartments   |  |  |  |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>Helen Agatha Henry  |  |  | e. 15. RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| 5. SEX<br>Female  |  |  | 6. DATE OF DEATH<br>December 5 1961   |  |  |  |   |  |  |  |
| 6. COLOR OR RACE<br>White   |  |  | 7. DATE OF BIRTH<br>March 29, 1921  |  |  |  |   |  |  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 9. AGE (In years last birthday)<br>40 yrs.  |  |  |  |   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>None   |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Virginia |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |  |
| 13. FATHER'S NAME<br>Charles F. Carbaugh  |  |  | 14. MOTHER'S MAIDEN NAME<br>Virginia Lemley   |  |  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>No   |  |  | 16. SOCIAL SECURITY NO.<br>227-22-0908  |  |  |  |   |  |  |  |
| 17. INFORMANT<br>The Medical Record   |  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Probable septicemia<br>DUE TO (b) Acute myelocytic leukemia with hepatomegaly (1800 grams) and splenomegaly (325 grams)<br>DUE TO (c)<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |  |  |  |   |  |  |  |
| 19. INTERVAL BETWEEN ONSET AND DEATH<br>14 days   |  |  | 20. 3 months  |  |  |  |   |  |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |   |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18)  |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br>19  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town)<br>(County)<br>(State)                      |  |  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 8, 1961 to Dec. 5, 1961, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 5, 1961, and that death occurred at 10:15 PM, from the causes and on the date stated above. |  |  |   |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br>J. David Heywood  |  |  | 22b. DATE SIGNED<br>December 6, 1961  |  |  |  |   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br>J. David Heywood, M.D.  |  |  | 22d. ADDRESS<br>The Clinical Center, the National Institutes of Health, Bethesda 14, Md.  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial-transit   |  |  | 23b. DATE THEREOF<br>12-8-61  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Prospect Hill Cem.               |  | 23d. LOCATION (City, town or county)<br>Front Royal, Virginia.  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>Robert A. Humphrey  |  |  | ADDRESS<br>Bethesda, Maryland   |  | 25a. REC'D BY REGISTRAR<br>DEC 8 '61                                   |  | 25b. REGISTRAR'S SIGNATURE<br>C. S. Farris                      |  |  |  |

[illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14132

## CERTIFICATE OF DEATH

Reg. Dist. No. 11101

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Ursuline Academy, Bethesda</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Ursuline Academy Forest Lane</u>  |  | e. STREET ADDRESS<br><u>4900 Forest Lane</u>  |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>Mother Agnes) Sarah Herkness</u>   |  | 4. DATE OF DEATH Month Day Year<br><u>December 28 19 61</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>       | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 2 1879</u>                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Mother Agnes of the Ursuline Nuns</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br><u>Philadelphia Pa.</u>    |
| 13. FATHER'S NAME<br><u>James Herkness</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Sarah Strain</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)<br><u>no</u>   |  | 16. SOCIAL SECURITY NO<br><u>none</u>   |   |
| 17. INFORMANT<br><u>Records of Ursuline Academy Bethesda 14 Maryland</u>   |  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CIRCULATORY COLLAPSE</u><br>DUE TO (b) <u>AURICULAR FIBRILLATION</u><br>DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>1 month</u><br><u>10+ years</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>MYELO NEPHRITIS &amp; CYSTITIS</u>   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><u>D. N. A.</u>                                 |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>MARCH, 1954</u> to <u>12/28, 1961</u> , that I last saw the deceased alive on <u>12/25</u> , 19 <u>61</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.   |  |   |   |
| ACTUAL SIGNATURE<br><u>Charles J. Savarese Jr.</u>   |  | ADDRESS (Street, city or town, state) DATE SIGNED<br><u>4890 Battery Lane Bethesda 12/28/61</u>   |   |
| PHYSICIAN'S NAME (Type)<br><u>Charles J. Savarese Jr. M.D.</u>   |  | <u>4890 Battery Lane Bethesda 14 Maryland</u>   |   |
| 22a. BURIAL-CREATION, REMOVAL (Specify)  | 22b. DATE THEREOF<br><u>12/30/1961</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>St. Oliver</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>St. Oliver D.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>P. Rafferty</u>   |  | ADDRESS<br><u>475-H-ST. N.W.</u>  |   |
| 24a. REC'D BY REGISTRAR<br><u>JAN 5 '62</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Charles J. Savarese</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of the report is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coroner Notified & Approved.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14133

14102

|   |                           |  |  |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md</b> b. COUNTY <b>Montgomery</b>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>   |                           | c. LENGTH OF STAY IN lb<br><b>3 years</b>  |  |
| d. NAME OF HOSPITAL (If in hospital, give street address) OR INSTITUTION<br><b>3000 McComas Ave.<br/>Kensington Gardens Sanitarium</b>  |                           | d. STREET ADDRESS<br><b>7816 Statford Pl.</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Camille</b> Middle <b>Hindmarsh</b> Last <b></b>  |                           | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>3</b> Year <b>1961</b>  |  |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>August 18, 1872</b> |
| 9. AGE (In years last birthday)<br><b>89 yrs.</b>   |                           | 10. IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>New York</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.</b>  |                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 13. FATHER'S NAME<br><b>Edmond H. Becker</b>  |                           | 14. MOTHER'S MAIDEN NAME<br><b>Emma Brica</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                           | 16. SOCIAL SECURITY NO<br><b>Unknown</b>   |  |
| 17. INFORMANT<br><b>Edmund Becker-Brother-same 2d</b>   |                           | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular Renal Failure</b><br>DUE TO <b>Generalized arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b></b><br>(c) <b></b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>years</b> |                           |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Fracture Rt. Radius Bone - one week.</b>  |                           |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><b>Fell Nov. 25, 1961 at Nursing Home</b>                  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m. <b></b>  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1951</b> to <b>Dec 3</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Dec. 2, 1961</b> , and that death occurred at <b>12:40 PM</b> from the causes and on the date stated above.  |                           |  |  |
| 22a. SIGNATURE<br><b>Thomas E. Curtin</b>   |                           | 22b. DATE SIGNED<br><b>Dec. 3, 1961</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>THOMAS E. CURTIN</b>  |                           | 22d. ADDRESS<br><b>4600 Connecticut Ave N.W. Wash. D.C.</b>  |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify)<br><b>Burial</b>   |                           | 23b. DATE THEREOF<br><b>12/5/61</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>  |                           | 23d. LOCATION (City, town, or county) (State)<br><b>Washington, D. C.</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>   |                           | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 6 '61</b>   |  |
|   |                           | 25b. REGISTRAR'S SIGNATURE<br><b>William S. Kane</b>   |  |



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14134  
14103

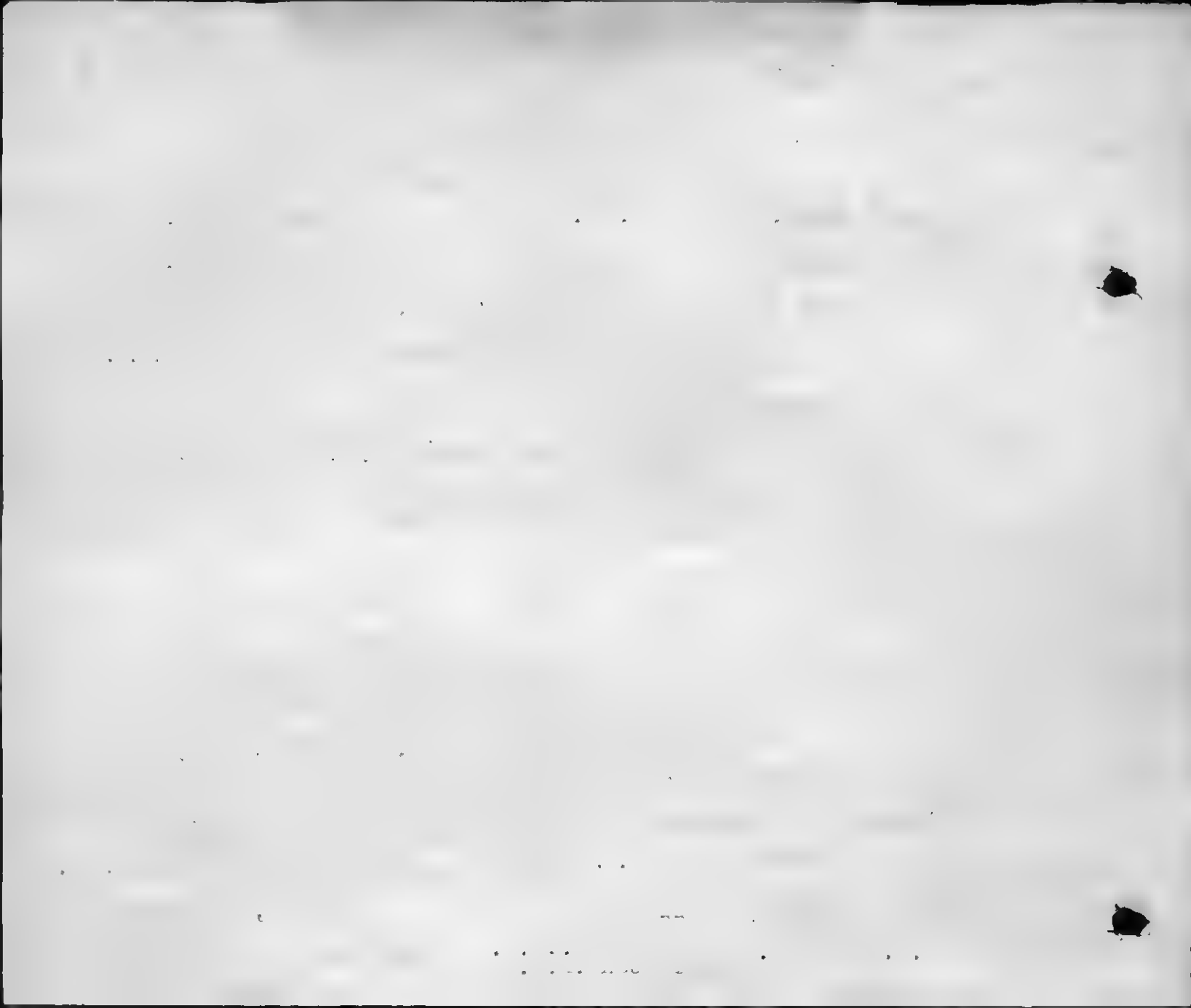
|   |                               |   |  |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San &amp; Hospital</u> |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u><br>d. STREET ADDRESS <u>1424 University Blvd.</u> |  |
| 3. NAME OF DECEASED (Type or print) <u>Jacob (NMN) Hoffman</u>  |                               | 4. DATE OF DEATH <u>Dec 1 1961</u>  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>5-27-95</u>                      |
| 9. AGE (In years last birthday) <u>66</u> yrs.  |                               | 10. IF UNDER 1 YEAR<br>Months <u>6</u> Days <u>1</u>  | 11. IF UNDER 24 HRS.<br>Hours <u>1</u> Min. <u>1</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Auto Salesman</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>George Hoffman</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Anna Kaplan</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Army W.W.I.</u>  |                               | 16. SOCIAL SECURITY NO. <u>569-11-2151</u>  |  |
| 17. INFORMANT <u>Hospital Records</u>   |                               | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                               |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u><br>DUE TO <u>ANGINA PECTORIS</u><br>DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>4-4-61</u>                     |                               |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS &amp; CHRONIC BRONCHITIS</u>   |                               |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>19</u>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/29/61</u> to <u>12/1/61</u> , that (I) (we) last saw the deceased alive on <u>11/20/61</u> , and that death occurred <u>6:00 AM</u> from the causes and on the date stated above.   |                               |   |  |
| 22a. SIGNATURE <u>David Stark</u> M.D.  |                               | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Harold Steinhilber, M.D.</u>  |                               | 22d. ADDRESS <u>1352 UNIVERSITY BLVD</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE THEREOF <u>12-4-61</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>MT. CEBARON CEMETERY</u>  |                               | 23d. LOCATION (City, town or county) (State) <u>HYATTSVILLE MD</u>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. ...</u>  |                               | 25a. REC'D BY REGISTRAR <u>DEC 5 '61</u>  |  |
| 25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>  |                               | 25c. REGISTRAR'S SIGNATURE  |  |



14135

{State}

YR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

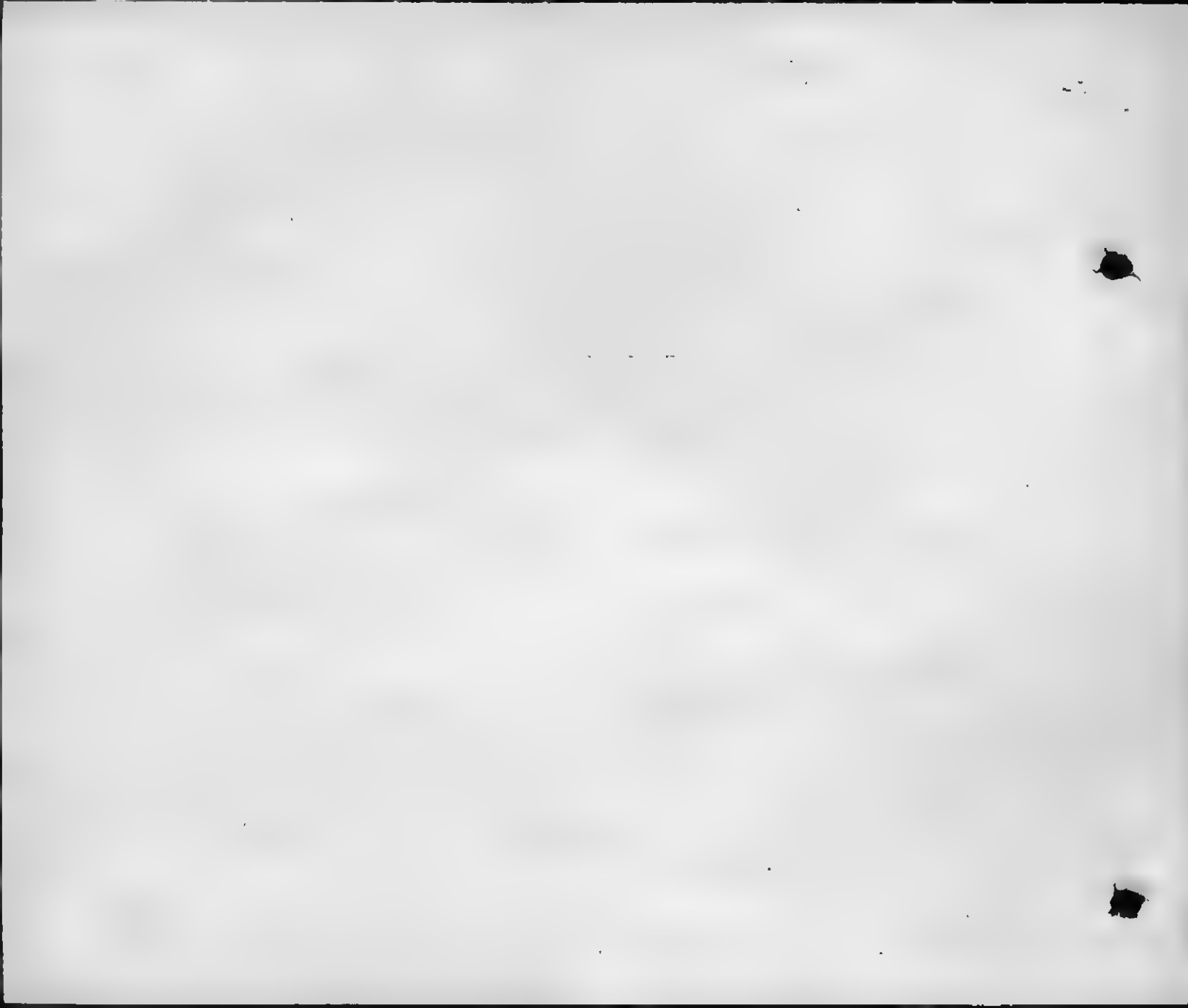
## CERTIFICATE OF DEATH

14136

14105

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>            |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>   |   |
| c. LENGTH OF STAY in 1b <b>2 hrs 25 min</b>  |   | d. STREET ADDRESS <b>10701 MCARTHUR BLVD.</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUBURBAN HOSPITAL</b>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>MILDRED E HOLT</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>12 5 19 61</b>  |   |
| 5. SEX <b>FEMALE</b>   | 6. COLOR OR RACE <b>WHITE</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11 11 09</b>                                     |
| 9. AGE (In years last birthday) <b>52 yrs.</b>   |   | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>   |   |
| 11. BIRTHPLACE (County & State or foreign country) <b>W. Va.</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |
| 13. FATHER'S NAME <b>Unknown</b>   |   | 14. MOTHER'S MAIDEN NAME <b>Unknown</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>  |   | 16. SOCIAL SECURITY NO. <b>None</b>  |   |
| 17. INFORMANT <b>Husband</b>   |   | Address <b>same rd</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>331X DUE TO</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>INTRACerebral hemorrhage</b><br>(c), stating the underlying cause last, <b>Hypertension</b><br>DUE TO (c) <b>-----</b> |   | INTERVAL BETWEEN ONSET AND DEATH <b>1-2 days</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>-----</b>  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>  | 20f. (City or town) (County) (State) <b>-----</b>                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec 5, 1961</b> to <b>Dec 5, 1961</b> (that I) (we) last saw the deceased alive on <b>Dec 5, 1961</b> and that death occurred at <b>7 PM</b> , from the causes and on the date stated above.  |   |  |   |
| 22a. SIGNATURE <b>John J. Curry</b>  |   | 22b. DATE SIGNED <b>12/5/61</b>  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>John J. Curry</b>  |   | 22d. ADDRESS <b>10620 Graceland St. Bethesda</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 23b. DATE THEREOF <b>12/8/61</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>   | 23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>   |   | 25a. REC'D BY REGISTRAR <b>DEC 8 '61</b>   |   |
|  |   | 25b. REGISTRAR'S SIGNATURE <b>C. S. Thorne</b>   |   |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the physician's name is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

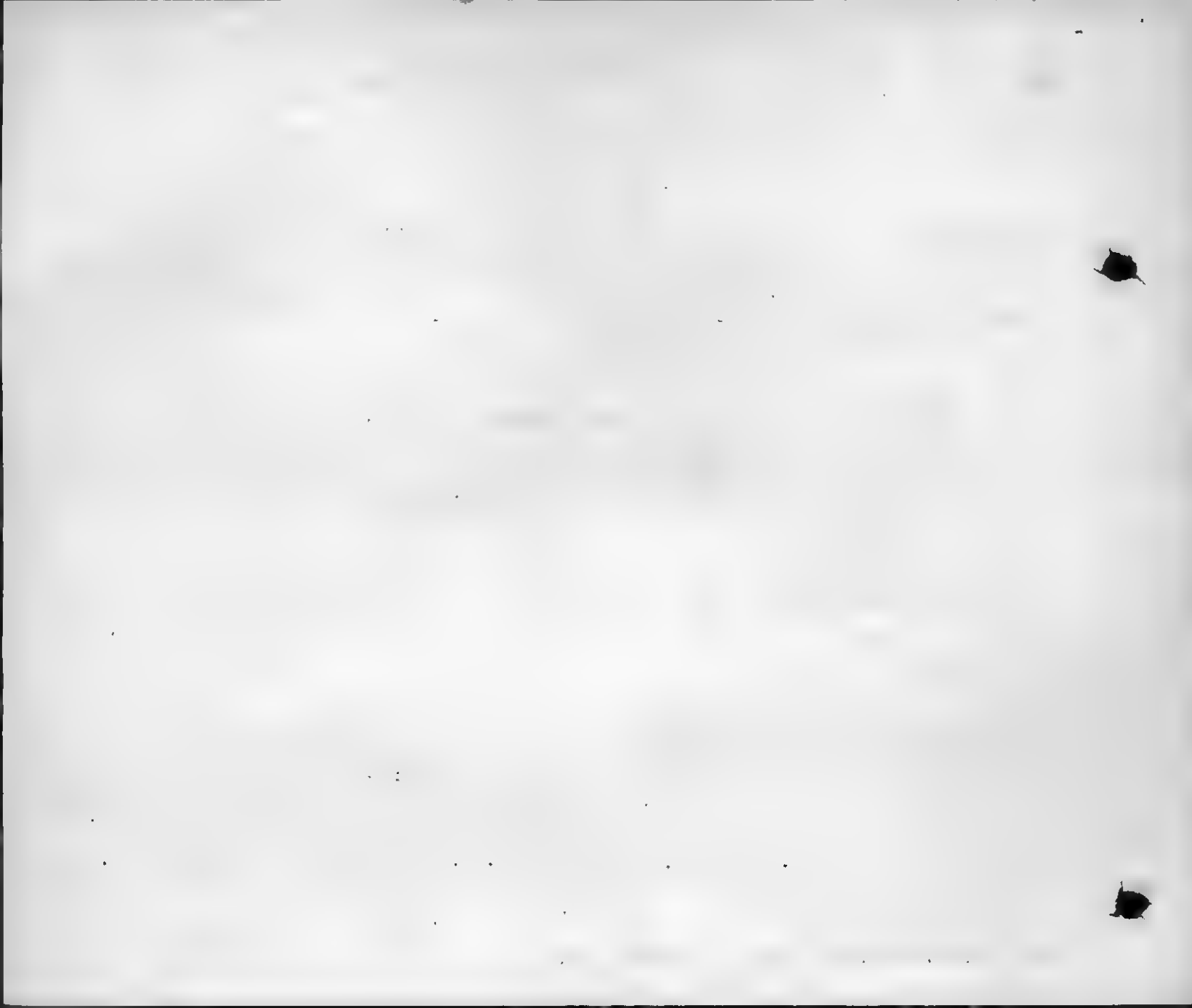
14137

## CERTIFICATE OF DEATH

Item 23b Film 6304 12/29/61 mh

14106

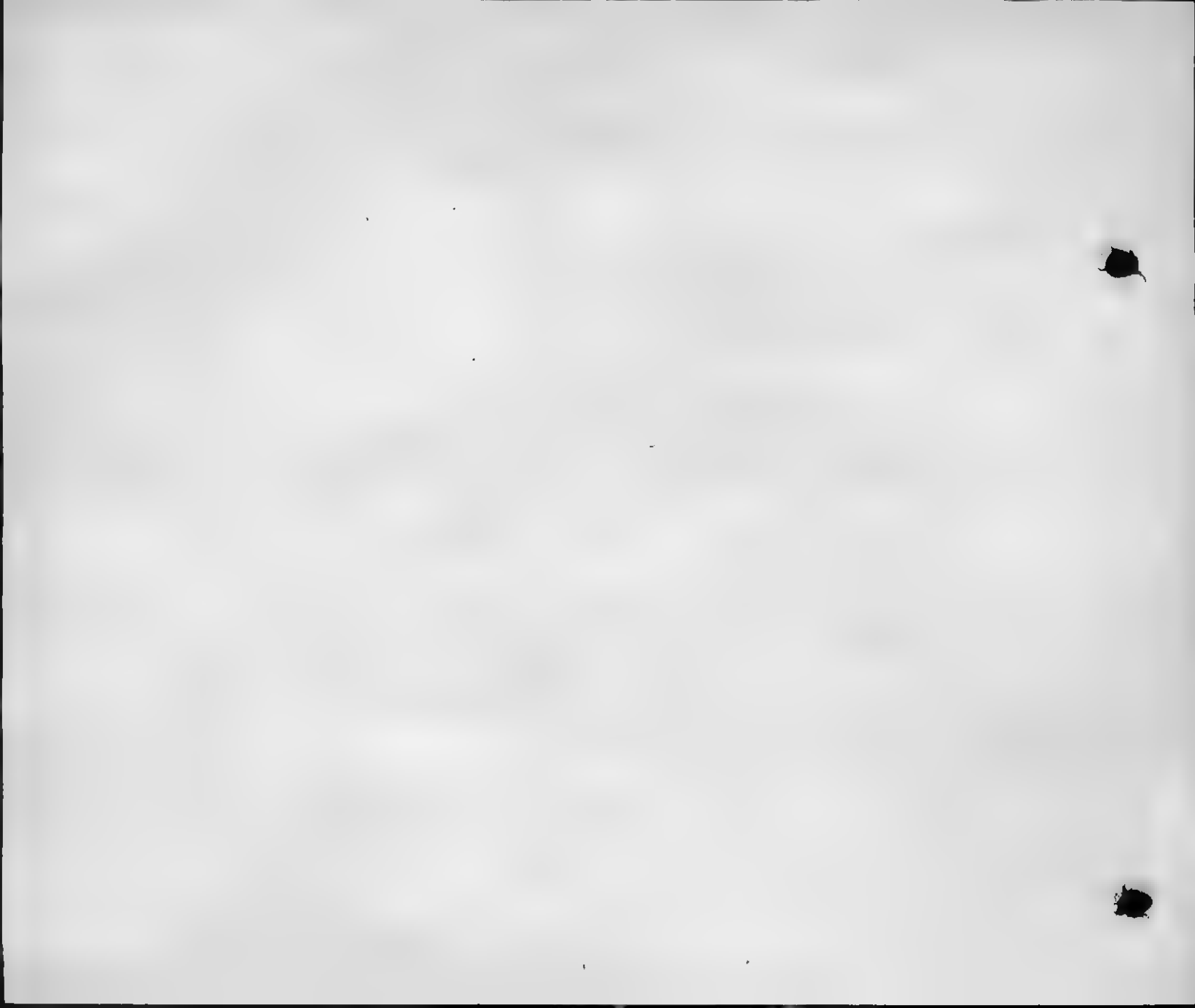
|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u><br>c. LENGTH OF STAY IN 1b <u>19 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>D. C.</u><br>b. COUNTY <u>Washington</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>4th St.</u><br>d. STREET ADDRESS <u>1,211 Shepard Street NW</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <u>Almer Lee Hopkins</u><br>First Middle Last<br>4. DATE OF DEATH <u>December 15, 1961</u><br>Month Day Year  |  | 5. SEX <u>Male</u><br>6. COLOR OR RACE <u>Negroid</u><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>8. DATE OF BIRTH <u>February 2, 1910</u><br>9. AGE (in years last birthday) <u>51</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Serviceman</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>Arkansas</u><br>11. BIRTHPLACE (County & State, or foreign country) <u>USA</u><br>12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  | 13. FATHER'S NAME <u>Elijah Hopkins</u><br>14. MOTHER'S MAIDEN NAME <u>Margaret Osborn</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u><br>16. SOCIAL SECURITY NO. <u>200,000</u><br>17. INFORMANT <u>Address</u>  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Reticulum cell sarcoma, massive, retroperitoneum</u><br>DUE TO (b) <u>200,000</u><br>DUE TO (c) <u>200,000</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>200,000</u>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>200,000</u><br>20c. TIME OF INJURY Month, Day, Year <u>19</u><br>Hour a.m. <u>3:15 PM</u> p.m. <u>3:15 PM</u><br>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>200,000</u><br>20f. (City or town) (County) (State) <u>200,000</u> |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21. I certify that (i) (this hospital) attended the deceased from <u>Nov. 25, 1961</u> to <u>Dec. 15, 1961</u> that (i) (we) last saw the deceased alive on <u>Dec. 15, 1961</u> , and that death occurred at <u>3:15 PM</u> from the causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE <u>Adam T. Thorp Jr.</u><br>22c. PHYSICIAN'S NAME (Type) <u>ADAM T. THORP JR. IT MC USN</u>  |  | 22b. DATE <u>December 15, 1961</u><br>22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u><br>23b. DATE THEREOF <u>Dec 20 1961</u><br>23c. NAME OF CEMETERY OR CREMATORY <u>Clinton National Cemetery</u><br>23d. LOCATION (City, town or county) (State) <u>Clinton, Virginia</u>   |  | 24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Hume</u><br>25a. REC'D BY REGISTRAR <u>DEC 21 '61</u><br>25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>  |  |



18  
FOR STATE  
HEALTH DEPT.

14138 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14107  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |                               |  |  |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY in 1b <u>D.O.A.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium Hospital</u>   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>404 E. Melbourne Avenue</u> |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Hosea Anson Hughes</u>   |                               | 4. DATE OF DEATH <u>December 3 1961</u><br>Month Day Year  |  |
| 5. SEX <u>male</u>   | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>May 12, 1891</u><br>Month Day Year |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>   |                               | 11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>  |  |
| 13. FATHER'S NAME <u>Hosea Hughes</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Nellie Barton</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>577-03-3175</u>   |  |
| 17. INFORMANT <u>wife</u>  |                               | Address <u>Same as above</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> |                               |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. 19   |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                       |                               |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschaw</u>  |                               | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>  |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                               | DATE SIGNED <u>12-3-61</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                               | 22b. DATE THEREOF  |  |
| 22c. NAME OF CEMETERY OR CREMATORY   |                               | 22d. LOCATION (City, town, or country) (State)   |  |
| 23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u>   |                               | 24a. REC'D BY REGISTRAR  |  |
| 24b. REGISTRAR'S SIGNATURE   |                               | DATE <u>DEC 5 '61</u>  |  |



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**JUNIAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

141108

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN b. <u>3 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>                               |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u><br>d. STREET ADDRESS <u>3208-Belling Rd.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Ida M. Hultgren</u>   |  | <b>4. DATE OF DEATH</b><br><u>Dec. 19 19 61</u>  |  | <b>5. SEX</b> <u>female</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |
| <b>8. DATE OF BIRTH</b><br><u>2-19-84</u>  |  | <b>9. AGE</b> (In years last birthday) <u>77</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days Hours Min.  |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Home maker</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |  |  |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pennsylvania</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>   |  | <b>13. FATHER'S NAME</b> <u>Fred Helzel</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>   |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>577-16-4859D</u> <b>17. INFORMANT</b> <u>Glady's M. Roesser / Above</u> Address <u>3 Stone As.</u>   |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute Myocardial Infarction</u><br>DUE TO <u>Septicemia</u><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Septicemia</u> (c) |  |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchopneumonia</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  |  |  |
| <b>20f. (City or town)</b>   |  | <b>20g. (County)</b>   |  | <b>20h. (State)</b>   |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec 8, 19 61</u> <b>to</b> <u>Dec 15, 19 61</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Dec 19, 19 61</u> <b>and that death occurred at</b> <u>8 PM</u> <b>from the causes and on the date stated above.</b>                            |  |  |  |   |  |  |  |
| <b>22a. SIGNATURE</b><br><u>V. R. Reedy</u>  |  | <b>22b. DATE SIGNED</b><br><u>12-19-61</u>   |  | <b>22c. PHYSICIAN'S NAME</b> (Type) <u>V. R. Reedy</u>  |  |  |  |
| <b>22d. ADDRESS</b><br><u>3701 Belmont Ch. Ch. Rd.</u>   |  | <b>22e. M.D.</b> <input checked="" type="checkbox"/> <b>22f. MED. DIRECTOR</b> <input type="checkbox"/> <b>22g. STAFF PHYS.</b> <input type="checkbox"/> |  |   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>   |  | <b>23b. DATE THEREOF</b> <u>12/22/61</u>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u>  |  |  |  |
| <b>23d. LOCATION</b> (City, town or county) <u>Rockville, Maryland</u>   |  | <b>23e. (State)</b>  |  |   |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u>  |  |  |  |   |  |  |  |
| <b>25a. REC'D BY REGISTRAR</b> <u>DEC 22 '61</u>   |  | <b>25b. REGISTRAR'S SIGNATURE</b>  |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |   |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |  |  |
| 14140 14109   |  |  |  |   |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |  |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  |  |  | c. LENGTH OF STAY IN Ill <u>3 days</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>  |  |  |  | d. STREET ADDRESS <u>8909 Ridge Place</u>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Kathryn L. Hutchison</u>   |  |  |  | 6. DATE OF DEATH <u>Dec. 26 1961</u>  |  |  |  | 9. AGE (In years last birthday) <u>75</u> yrs.   |  |  |  |
| 5. SEX <u>Female</u>  |  |  |  | 6. COLOR OR RACE <u>White</u>   |  |  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Iowa</u>  |  |  |  |
| 13. FATHER'S NAME <u>George W. Young</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Weber</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  |  |  | 16. SOCIAL SECURITY NO. <u>Janice H. Ale (daughter)</u>   |  |  |  | 17. INFORMANT <u>same as above</u>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>332X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Thrombosis</u><br>(c) <u>Generalized Arteriosclerosis</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 10 DAYS</u><br>YRS <u>YRS</u> |  |  |  |   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour e.m. p.m. <u>19</u>  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  |
| 20f. (City or town)   |  |  |  | 20g. (County)   |  |  |  | 20h. (State)   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/27</u> 19 <u>61</u> to <u>Dec 26</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Dec 26</u> 19 <u>61</u> , and that death occurred at <u>12/26/61</u> M, from the causes and on the date stated above.  |  |  |  |   |  |  |  |  |  |  |  |
| 22a. SIGNATURE <u>Leo I. Donovan MD</u>   |  |  |  | 22b. DATE SIGNED <u>12/26/61</u>  |  |  |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>LEO I DONOVAN MD</u>  |  |  |  | 22d. ADDRESS <u>8218 WISC. AVE</u>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |  |  | 23b. DATE THEREOF <u>12/29/61</u>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cem. Rockville Pike MD</u>  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Time Name</u>  |  |  |  | 25. REC'D BY REGISTRAR <u>5101</u>  |  |  |  | 25b. REGISTRAR'S SIGNATURE <u>DEC 29 '61</u>   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

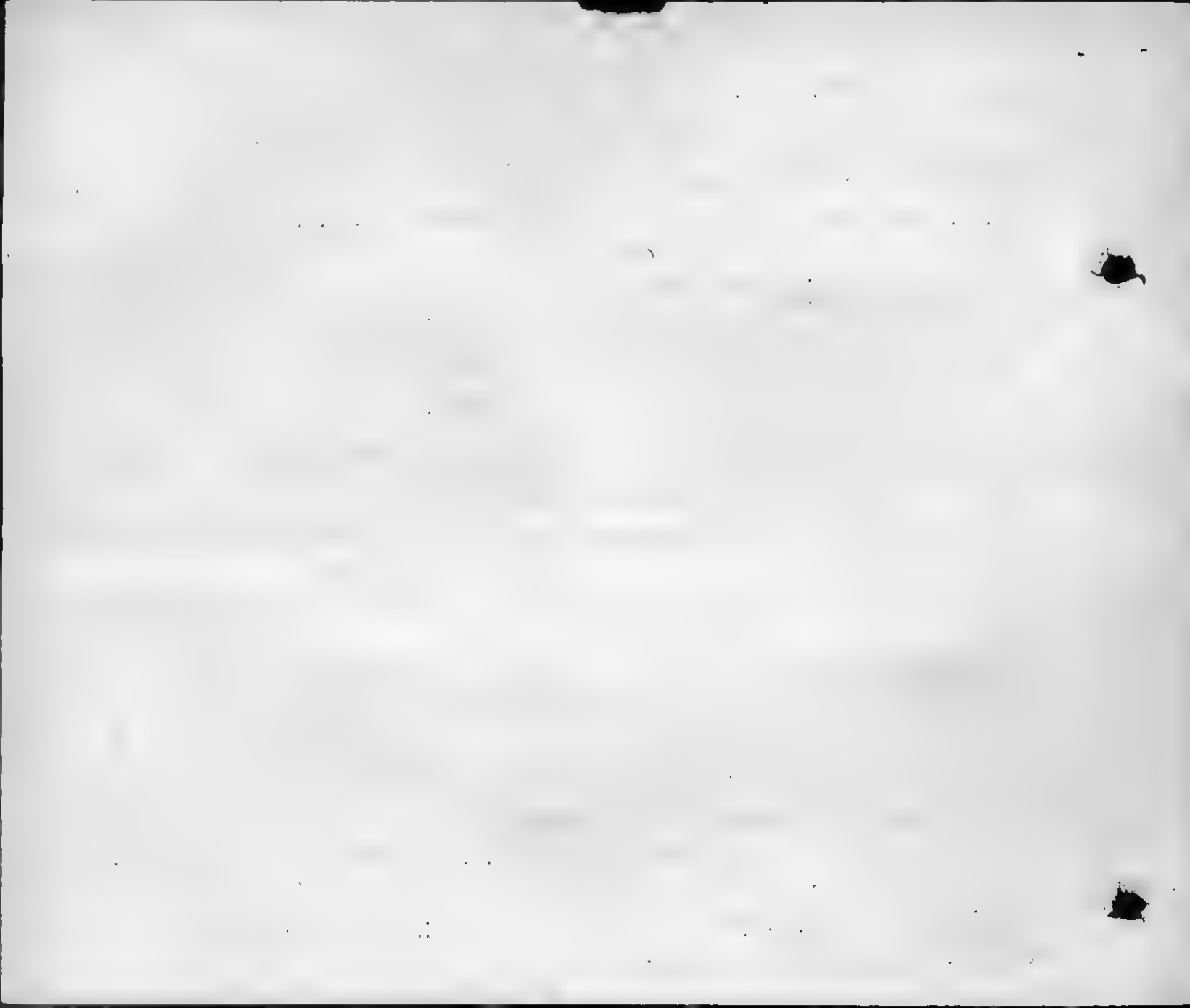
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

141110

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>COUNTY <u>Montgomery</u><br>M  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Washington</u><br>b. COUNTY <u>DC</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>District of Columbia</u><br>d. STREET ADDRESS<br><u>908 Shepard St. N.W.</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda (Rural)</u>   |  | c. LENGTH OF STAY IN 1b<br><u>18 days</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>U. S. Naval Hospital Bethesda</u>  |  | a. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Rose (N)</u>   |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>9</u> Year <u>19 61</u>  |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>Caucasian</u>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><u>1 Feb 1875</u>   |  |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  | 9. AGE (In years last birthday)<br><u>86</u> yrs.   |  |
| 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Russia</u>  |  |
| 13. FATHER'S NAME<br><u>Unknown</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><u>No</u>  |  | 17. INFORMANT<br><u>(Son) Maurice Jarson</u>  |  |
| 16. SOCIAL SECURITY NO.<br><u>None</u>  |  | Address <u>Pensacola, Fla.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Encephalopathy</u><br>DUE TO <u>arteriosclerosis and hypertension undetermined</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.<br>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br>21. I certify that (I) (this hospital) attended the deceased from <u>21 Nov 1961</u> to <u>9 Dec 1961</u> , that (X) (we) last saw the deceased alive on <u>9 Dec 1961</u> and that death occurred at <u>115PM</u> , from the causes and on the date stated above.<br>22a. SIGNATURE<br><u>Paul G. Linaweaver</u><br>22b. DATE SIGNED<br><u>9 Dec 1961</u><br>22c. PHYSICIAN'S NAME (Type)<br><u>LCDR Paul G. Linaweaver MC USN</u><br>22d. ADDRESS<br><u>U.S. Naval Hospital, Bethesda, Md.</u> |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>10 Dec 1961</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>EZRA'S ISRAEL</u>  |  | 23d. LOCATION (City, town or county) (State)<br><u>CAPITAL HEIGHTS, MARYLAND</u>  |  |
| 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 13 '61</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur E. Hase</u>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE D.C. b. COUNTY D.C.  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington 20, D.C.  
d. STREET ADDRESS 800 Barnaby Street,

3. NAME OF DECEASED (Type or print) Jeffries, Baby Boy  
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH 12/9/61  
9. AGE (In years last birthday) 12 10. IF UNDER 1 YEAR Months 1 Days 16 11. IF UNDER 24 HRS. Hours 16 Min. 12

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no 10b. KIND OF BUSINESS OR INDUSTRY no 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME Larry Nicholas Ladrido 14. MOTHER'S MAIDEN NAME Marsha Elaine Jeffries

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. no 17. INFORMANT mother Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Atelectasis DUE TO 7/2.5  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (c)  
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

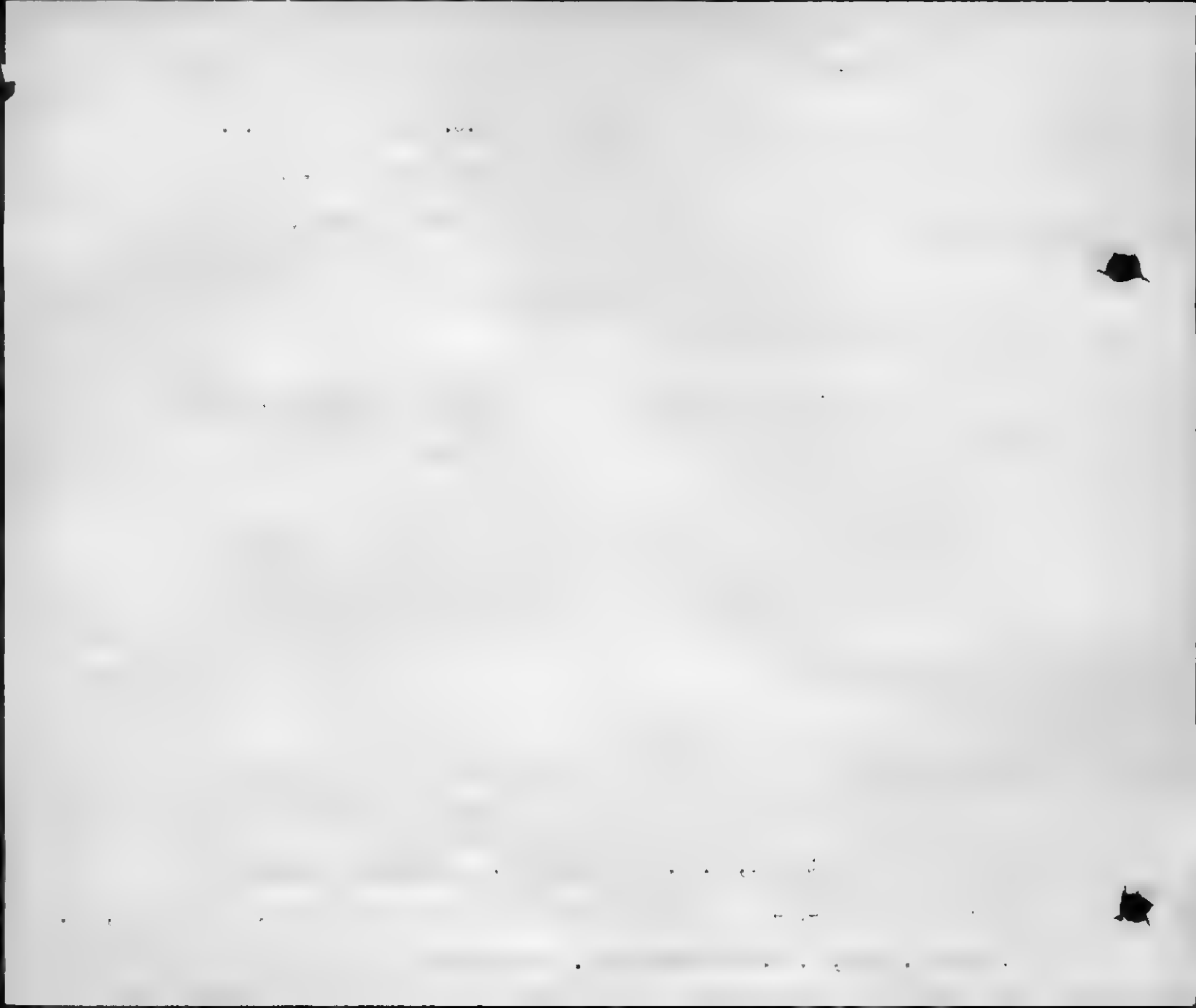
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-9-61 to 12-11-61, that (I) (we) last saw the deceased alive on 12-11-61, and that death occurred at 12-11-61 M, from the causes and on the date stated above.

22a. SIGNATURE Robert A. Hare 22b. DATE SIGNED 12-14-61  
22c. PHYSICIAN'S NAME (Type) Robert A. Hare, M. D. 7105 Riggs Rd., Lewisdale, Maryland  
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 23b. DATE THEREOF 12-12-61 23c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital, Takoma Park, Md. 23d. LOCATION (City, town or county) (State)  
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Washington San. & Hospital 25a. REC'D BY REGISTRAR DEC 18 '61 25b. REGISTRAR'S SIGNATURE Robert A. Hare

211151XVI



1  
FOR STATE  
HEALTH DEPT.

REPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM  
5M 9/60

Item 18 Film 307 2-20 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14143 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14112

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN TB <u>2 wks</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>909 Maplewood Cuz</u>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>monty</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>d. STREET ADDRESS <u>909 Maplewood Cuz</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>George Ellis Johnson</u><br>First Middle Last<br>5. SEX <u>male</u><br>6. COLOR OF RACE <u>white</u><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>auto</u> |   | 4. DATE OF DEATH <u>Dec 31 1961</u><br>8. DATE OF BIRTH <u>6-2-13</u><br>9. AGE (In years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.<br>11. BIRTHPLACE (State or foreign country) <u>Frederickshagen, S. C.</u><br>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |  |
| 13. FATHER'S NAME <u>George E. Johnson</u><br>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u><br>16. SOCIAL SECURITY NO. <u>579-05-9948</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Frances E. George</u><br>17. INFORMANT <u>Ella Furharty</u> Address <u>Stun 2</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>IPEDIDIANH</u> Congestive heart failure<br><u>581.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fatty degeneration of liver - Edema of lungs</u><br>DUE TO (c) <u>Chronic alcoholism</u>   |   | INTERVAL BETWEEN ONSET AND DEATH <u>AWDIDIANH</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Found dead at foot of basement stairs, at home</u>   |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)<br><u>Fell down basement stairs at home</u>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br><u>Dec - 12-31 1961</u><br>Hour a.m. <u>8:00</u>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>   | 20f. (City or town) <u>Takoma Park</u> (County) <u>monty</u> (State) <u>md</u> |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |   |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u><br>EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <u>12-31-61</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>   |   | 22b. DATE THEREOF <u>Jan. 3/62</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>   |   | 22d. LOCATION (City, town, or country) (State) <u>Colma Manor, Md.</u>   |  |
| 23. FUNERAL DIRECTOR <u>Nalley's Funeral Home, Inc.</u> ADDRESS <u>Mt. Rainier Maryland</u>  |   | 24a. REC'D BY REGISTRAR <u>JAN 4 '62</u> 24b. REGISTRAR'S SIGNATURE <u>J. S. Kraw</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

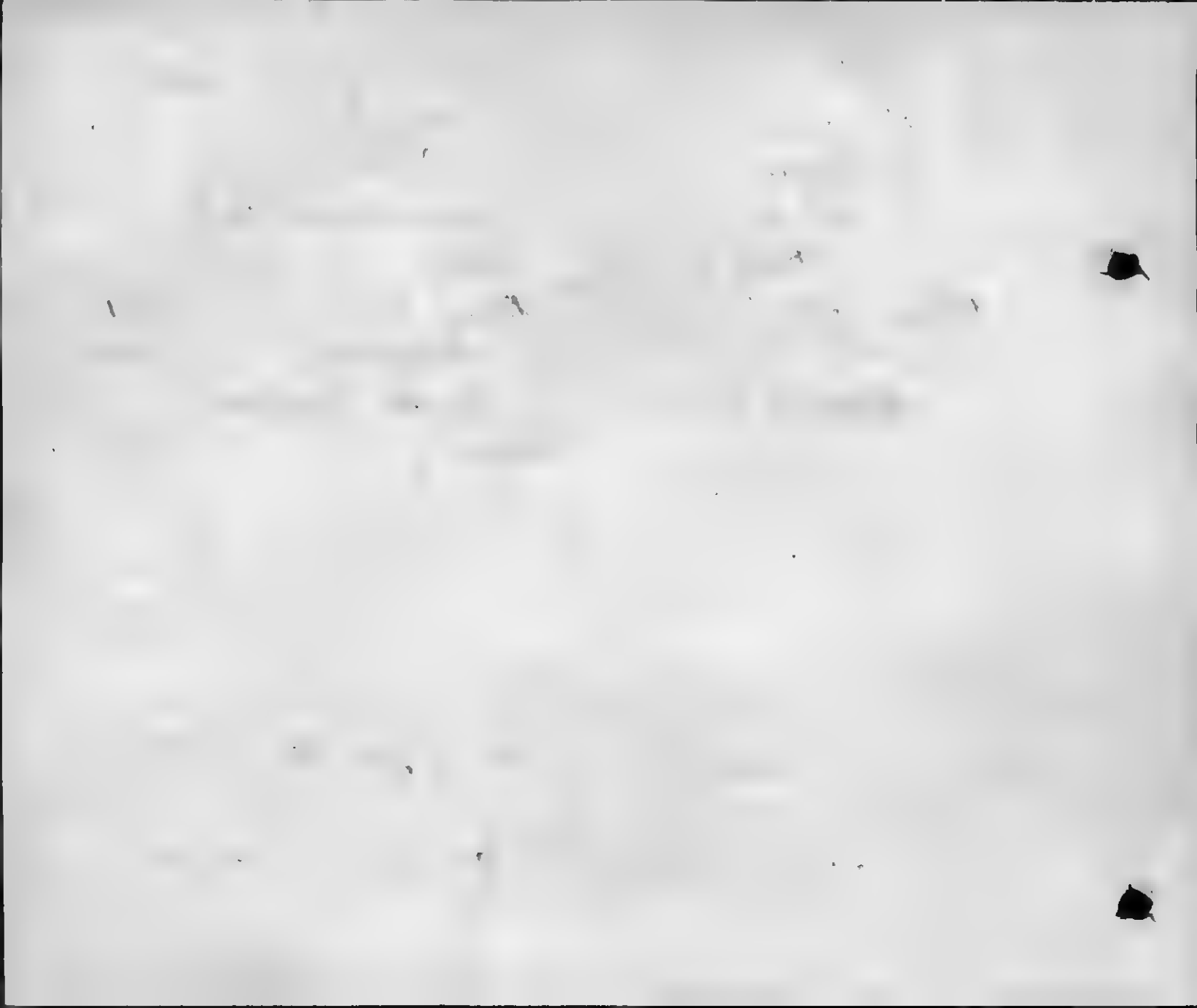
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

14144

14113

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b <u>1 hour</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutions: Residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u><br>d. STREET ADDRESS <u>12622 Shaulmax St.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>5. SEX <u>Male</u><br>6. COLOR OR RACE <u>White</u><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>4. DATE OF DEATH</b><br><u>Dec 1, 1961</u><br>8. DATE OF BIRTH <u>Dec 1, 1961</u><br>9. AGE (In years last birthday) <u>0</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>-</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>  |  | <b>13. FATHER'S NAME</b> <u>Herbert Jones</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Virian Burgess</u><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>-</u><br><b>16. SOCIAL SECURITY NO.</b> <u>-</u><br><b>17. INFORMANT</b> <u>Father -</u>   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause or line for (e), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e) <u>Cardio-respiratory failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Anencephaly</u><br>DUE TO (b) <u>750X</u><br>DUE TO (c) <u>-</u> |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> <u>-</u>  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u><br>Hour a.m. <u>-</u> p.m. <u>-</u>  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>-</u>   |  | <b>20f. (City or town)</b> <u>-</u> (County) <u>-</u> (State) <u>-</u>   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec 1, 1961, to Dec 1, 1961,</u> that (I) (we) last saw the deceased alive on <u>Dec 1, 1961,</u> and that death occurred at <u>7:35 PM</u> , from the causes and on the date stated above.  |  |  |  |
| <b>22a. SIGNATURE</b> <u>Joseph O'Neil</u><br><b>22c. PHYSICIAN'S NAME (Type)</b> <u>Joseph O'Neil</u>   |  | <b>22b. DATE SIGNED</b> <u>12/1/61</u><br><b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/><br><b>22d. ADDRESS</b> <u>809 Viers Mill Rd. Rockville Md.</u>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>CREMATION</u><br><b>23b. DATE THEREOF</b> <u>12-2-61</u>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>SUBURBAN HOSPITAL</u><br><b>23d. LOCATION (City, town or county)</b> <u>BETHESDA, MARYLAND</u>  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Amelia C. Carter</u><br><u>(per F.B.)</u><br><b>ADDRESS</b> <u>Suburban Hosp. Bethesda, Maryland</u>  |  | <b>25a. REC'D BY REGISTRAR</b> <u>DEC 18 '61</u><br><b>25b. REGISTRAR'S SIGNATURE</b> <u>(Signature)</u>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14145

## CERTIFICATE OF DEATH

14114

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda (Rural)</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington</u>  |  |
| c. LENGTH OF STAY IN 1b<br><u>1 day</u>  |  | d. STREET ADDRESS<br><u>926 Massachusetts Ave. NE</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>U. S. Naval Hospital</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First <u>Olivia</u> Middle <u>Mae</u> Last <u>Jones</u>   |  | <b>4. DATE OF DEATH</b><br>Month <u>December</u> Day <u>12</u> Year <u>1961</u>  |  |
| <b>5. SEX</b><br><u>Female</u>   |  | <b>6. COLOR OR RACE</b><br><u>Caucasian</u>  |  |
| <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><u>October 16, 1881</u>   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Pennsylvania</u>  |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>USA</u>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u>  |  |
| <b>13. FATHER'S NAME</b><br><u>Thomas Cooper</u>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Ellen Cushcar</u>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give year or dates of service)<br><u>No</u>  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>HUSBAND: Calvin A. Jones, Same as #2</u>  |  |
| <b>17. INFORMANT</b><br><u>HUSBAND: Calvin A. Jones, Same as #2</u>  |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>congestive heart failure</u><br>DUE TO <u>arteriosclerotic heart disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>months</u><br>DUE TO (c) |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>  |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)  |  |
| <b>21. I certify that</b> (this hospital) attended the deceased from <u>Dec. 12, 1961</u> , to <u>Dec. 12, 1961</u> , that (X) (we) last saw the deceased alive on <u>Dec. 12, 1961</u> , and that death occurred at <u>11:00 PM</u> from the causes and on the date stated above. |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Paul G. Lin</u>  |  | <b>22b. DATE SIGNED</b><br><u>December 13, 1961</u>  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>PAUL G. LIN</u>  |  | <b>22d. ADDRESS</b><br><u>U. S. Naval Hospital, Bethesda, Md.</u>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>  |  | <b>23b. DATE THEREOF</b><br><u>12-16-61</u>  |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Columbia Gardens</u>   |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Arlington, Va.</u>   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Lee Funeral Home</u>   |  | <b>25a. REC'D BY REGISTRAR</b><br><u>DEC 15 '61</u>  |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur E. Kraus</u>  |  |  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14146

14115

### 1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

MARYLAND

c. LENGTH OF STAY IN

### 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE  
MARYLAND

b. COUNTY  
MONTGOMERY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

OLNEY

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

MONTGOMERY GENERAL HOSPITAL

### 3. NAME OF DECEASED

(Type or print)

First

PAUL

Middle

NMN

Last

Judson

### 4. DATE OF DEATH

Month

12

Day

4

Year

19 61

### 5. SEX

MALE

### 6. COLOR OR RACE

WHITE

### 7. MARRIED

NEVER MARRIED ☒

### 8. DATE OF BIRTH

4/6/61

### 9. AGE (In years last birthday)

### 10. IF UNDER 1 YEAR

Months

Days

8

### 11. IF UNDER 24 HRS.

Hours

Min.

19 61

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

### 13. FATHER'S NAME

ROBERT JUDSON

### 14. MOTHER'S MAIDEN NAME

MARCIA BARTLETT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

HOSPITAL RECORDS

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

#### PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

BRONCHOPNEUMONIA, BILATERAL.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

TRACHEOBRONCHITIS, SEVERE.

(c)

#### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

MONGOLISM, CONGENITAL.

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

### 20c. TIME OF INJURY

Month, Day, Year

### 20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

### 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

### 20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from JUNE 17 to DEC. 4, 19.61, that (I) (we) last saw the deceased alive on DEC. 3, 19.61, and that death occurred at M, from the causes and on the date stated above.

### 22a. SIGNATURE

Charles S. Whitaker, M.D.

M.D.

### ATTENDING PHYS.

### MED. DIRECTOR

### STAFF PHYS.

12/4/61

### 22c. PHYSICIAN'S NAME (Type)

CHARLES S. WHITAKER, M.D.

CLARKSVILLE, MARYLAND

### 23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

### 23b. DATE THEREOF

12-5-61

### 23c. NAME OF CEMETERY OR CREMATORY

London Park

### 23d. LOCATION (City, town or county)

Baltimore, Md

### 24. FUNERAL DIRECTOR'S SIGNATURE

Funeral Home, Baltimore City, Md

### 25a. REC'D BY REGISTRAR

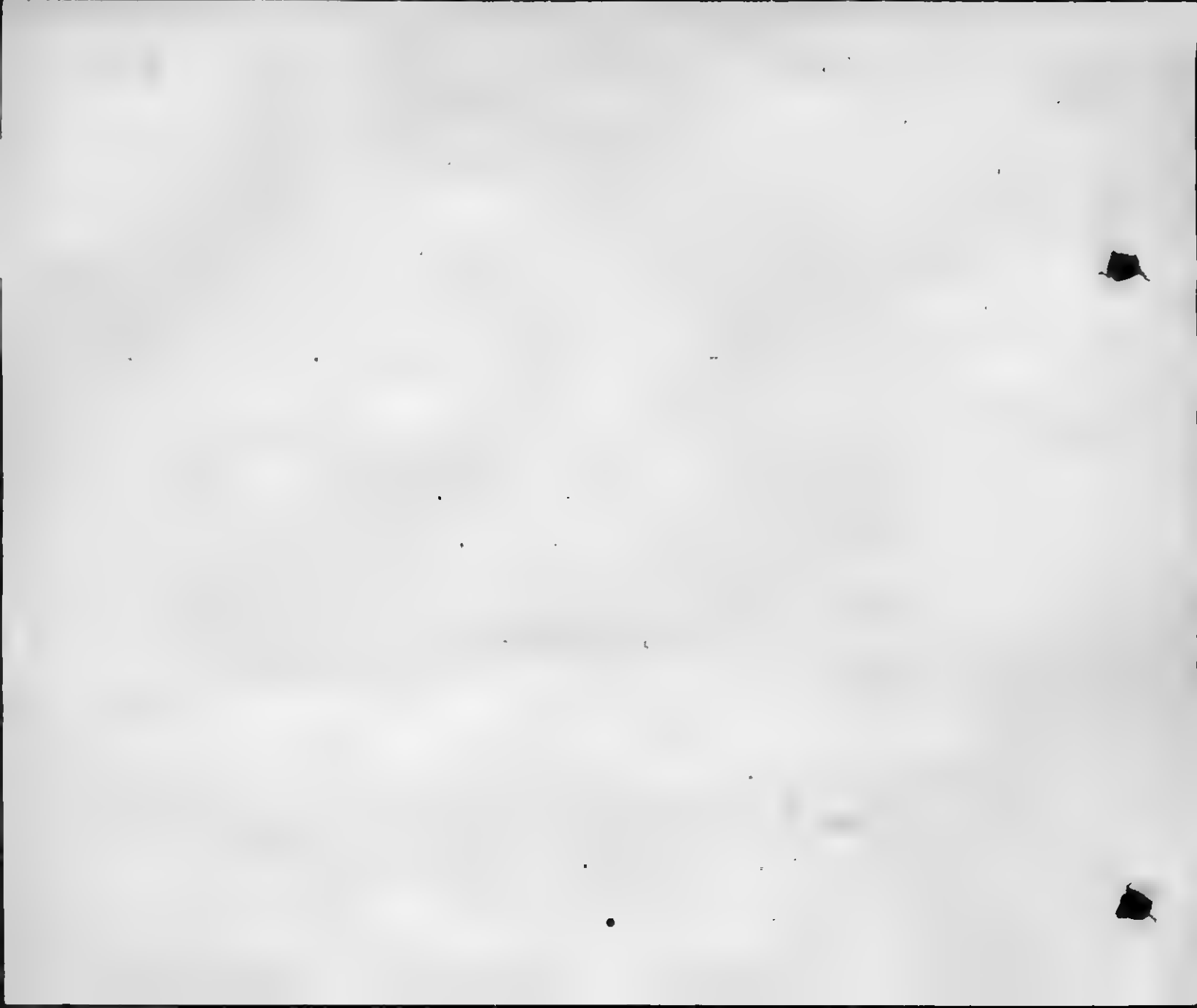
### 25b. REGISTRAR'S SIGNATURE

DATE DEC 6 '61

Charles S. Whitaker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove sections 1 and 2 and send them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7 61

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |  |   |   |  |  |  |
|--|--|---|--|--|---|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |  |   |   |  |  |  |
| 14147  |  |   |  |  | 14116   |   |  |  |  |
| 1 PLACE OF DEATH   |  |   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)               |   |  |  |  |
| a. COUNTY<br><b>Montgomery</b>   |  |   |  |  | e. STATE<br><b>Kentucky</b>   |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>  |  |   |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Anhorige</b> |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>U.S. Naval Hospital</b>   |  |   |  |  | d. STREET ADDRESS   |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)  |  |   |  |  | 4. DATE OF DEATH  |   |  |  |  |
| First Middle Last<br><b>Josephine Bedinger KIEREN</b>  |  |   |  |  | Month Day Year<br><b>December 31 1961</b>   |   |  |  |  |
| 5 SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Caucasian</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>July 8, 1897</b>       |  | 9. AGE (In years last birthday) <b>64</b> yrs. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 13. FATHER'S NAME<br><b>Daniel L. Bedinger</b> |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Eleanor G. Campbell</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> |  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>Hospital Records</b>      |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |   |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>172X</b> <b>Spontaneous Carcinoma of endometrium</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c), stating the underlying cause last. DUE TO  |  |   |  |  |   |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |   |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |   |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  |  |   |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |   |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  |  |   |  |  |   |   |  |  |  |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  |   |  |  |   |   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  |  |   |   |  |  |  |
| 20f. (City or town) (County) (State)   |  |   |  |  |   |   |  |  |  |
| 21. I certify that <b>XX</b> (this hospital) attended the deceased from <b>6 December 1961</b> to <b>31 December 1961</b> , that <b>XX</b> (we) last saw the deceased alive on <b>31 December 1961</b> , and that death occurred at <b>2:45P</b> M, from the causes and on the date stated above |  |   |  |  |   |   |  |  |  |
| 22a. SIGNATURE<br><b>Robert H. Perkins</b> M.D.  |  |   |  |  |   |   |  |  |  |
| 22b. DATE<br><b>DECEMBER 31, 1961</b>  |  |   |  |  |   |   |  |  |  |
| 22c. PHYSICIAN'S<br><b>ROBERT H. PERKINS T MC USN</b>  |  |   |  |  |   |   |  |  |  |
| 22d. ADDRESS<br><b>U. S. Naval Hospital Bethesda, Md.</b>  |  |   |  |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |   |  |  |   |   |  |  |  |
| 23b. DATE THEREOF<br><b>1-5-62</b>   |  |   |  |  |   |   |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |  |   |  |  |   |   |  |  |  |
| 23d. LOCATION (City, town or county) (State)<br><b>Arlington, Virginia</b>   |  |   |  |  |   |   |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert H. Humphrey</b>  |  |   |  |  |   |   |  |  |  |
| ADDRESS <b>Bethesda, Md.</b>   |  |   |  |  |   |   |  |  |  |
| 25a. REC'D BY REGISTRAR<br><b>JAN 3 '62</b>  |  |   |  |  |   |   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John S. Hume</b>  |  |   |  |  |   |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

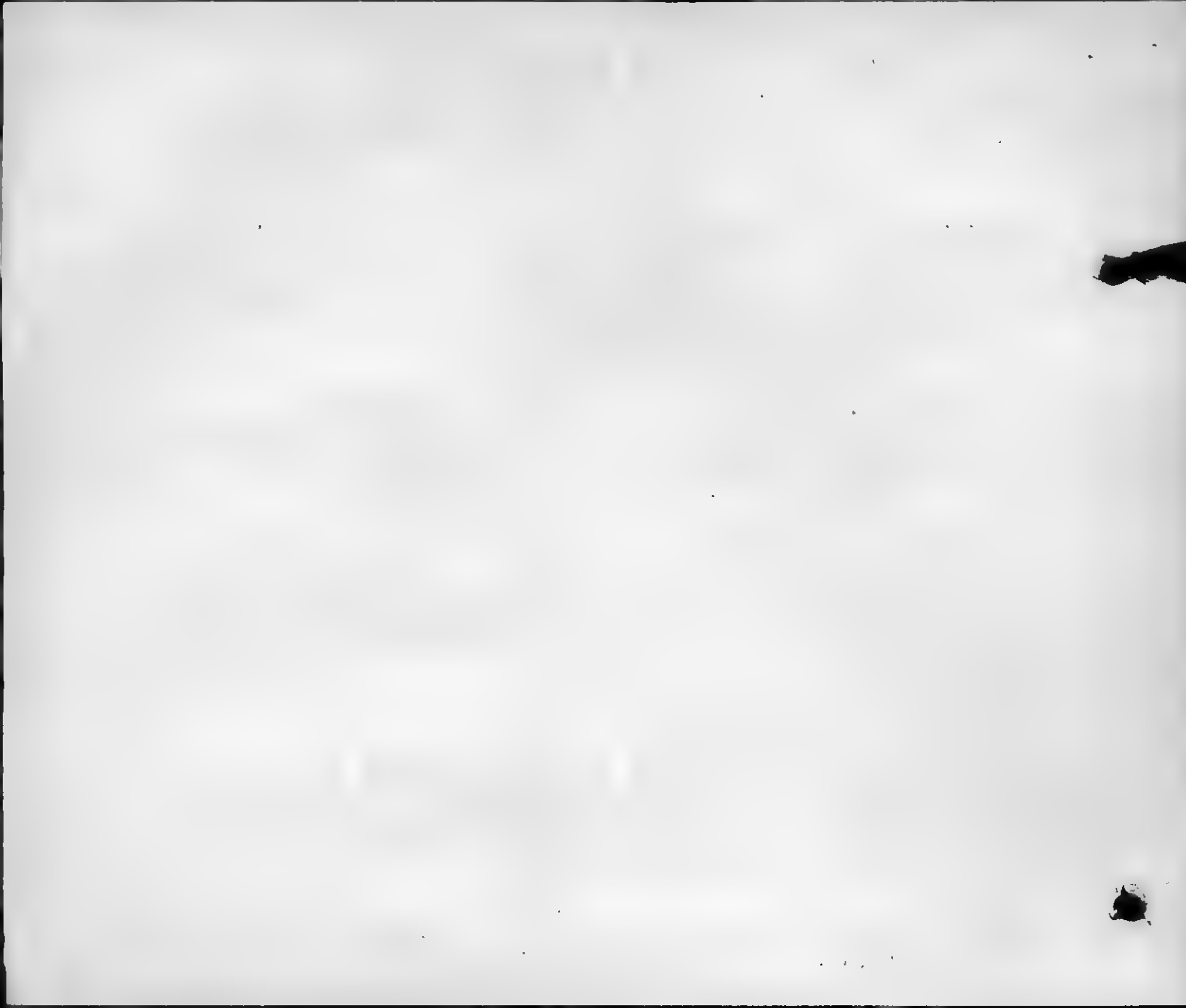
14148

## CERTIFICATE OF DEATH

Items 11 & 12 Film G303 12/26/61 mh

141172

|  |  |  |   |
|--|--|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MONTGOMERY</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u><br>c. LENGTH OF STAY IN 1b <u>MARYLAND</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. NAVAL HOSPITAL</u>                                    |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u><br>d. STREET ADDRESS <u>7913 DEEP WELL DR.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>EARLE HILL KINCAID</u><br>First Middle Last   |  | <b>4. DATE OF DEATH</b><br><u>DECEMBER 13 1961</u><br>Month Day Year   |   |
| <b>5. SEX</b><br><u>Male</u>   | <b>6. COLOR OR RACE</b><br><u>Can</u>  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br><u>8-19-94</u>   |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>   |   |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>West Virginia</u>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u>  |   |
| <b>13. FATHER'S NAME</b><br><u>CHARLES A. KINCAID</u>  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>EMMA GILBERT</u>   |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give year or dates of service)   |  | <b>16. SOCIAL SECURITY NO.</b>   |   |
| <b>17. INFORMANT</b><br><u>Hospital Records</u>  |  | Address  |   |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>arteriosclerosis and hypertension</u><br>(c) <u>16 years</u><br>DUE TO<br>cause last, (c) <u>16 years</u> |  |  |   |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>   |  |  |   |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)   |   |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  | <b>20f. (City or town)</b> (County) (State) |
| <b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>13 DEC 1961</u> to <u>13 DEC 1961</u> , that (x) (we) last saw the deceased alive on <u>13 DEC 1961</u> , and that death occurred <u>11:00 PM</u> from the causes and on the date stated above.  |  |  |   |
| <b>22a. SIGNATURE</b><br><u>David Goldblatt</u> M.D.<br><b>22c. PHYSICIAN'S NAME</b> (Type) <u>DAVID G. GOLDBLATT LT MC USA</u>  |  | <b>22b. DATE SIGNED</b><br><u>14 Dec 61</u><br><b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/><br><b>22d. ADDRESS</b><br><u>U. S. Naval Hospital, Bethesda, Md.</u>  |   |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u>   |  | <b>23b. DATE THEREOF</b> <u>12-17-61</u>   |   |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b>  |  | <b>23d. LOCATION</b> (City, town or county) (State)  |   |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>James L. ...</u>   |  | <b>25a. REC'D BY REGISTRAR</b> <u>DEC 18 '61</u>   |   |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>...</u>  |  |  |   |









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

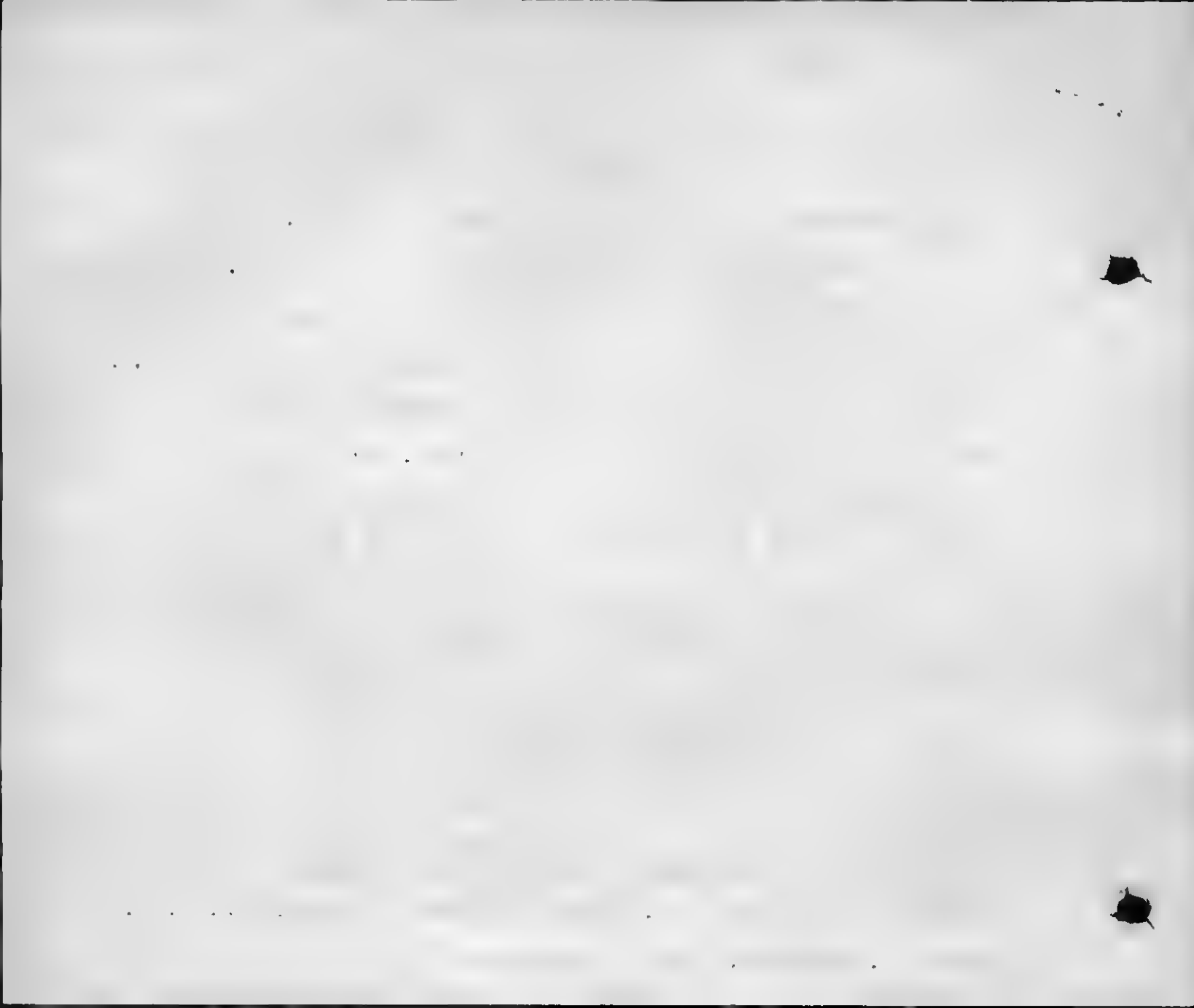
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14150

CERTIFICATE OF DEATH

14119

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MONTGOMERY</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u><br>c. LENGTH OF STAY IN b. <u>21 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u><br>d. STREET ADDRESS <u>2902 MC COMAS AVE.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>CATHERINE L. KOUNS</u><br>First Middle Last<br>b. COLOR OR RACE <u>White</u><br>c. MARIED <input type="checkbox"/> NEVER MARIED <input type="checkbox"/> B. DATE OF BIRTH <u>2/16/95</u><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/><br>9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>None</u><br>11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u><br>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |   |  |
| 13. FATHER'S NAME <u>Dillon</u><br>14. MOTHER'S M.A.DEN NAME <u>Mary Stone</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u><br>16. SOCIAL SECURITY NO. <u>16-11-1111</u><br>17. INFORMANT <u>Daughter Mrs. Mary Botts</u> Address <u>Same as above</u>   |  |   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO <u>MASSIVE ATELECTASIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>RESPIRATORY INSUFFICIENCY</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BLEEDING GASTRIC ULCER - SUBTOTAL GASTRECTOMY FOR</u><br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u><br>20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1015 SPRING ST. SPRING MD.</u><br>20d. (City or town) (County) (State)  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>DEC 6, 1961</u> to <u>DEC 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>DEC 14, 1961</u> , and that death occurred at <u>SSA</u> , from the causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE <u>John P. Haberlin</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22c. PHYSICIAN'S NAME (Type) <u>HABERLIN</u> 22d. ADDRESS <u>1015 SPRING ST. SPRING MD.</u><br>22b. DATE SIGNED <u>12-14-61</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>12/16/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>  |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> ADDRESS <u>DATE DEC 18 '61</u><br>25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>C. J. &amp; K. R.</u>   |  |   |  |



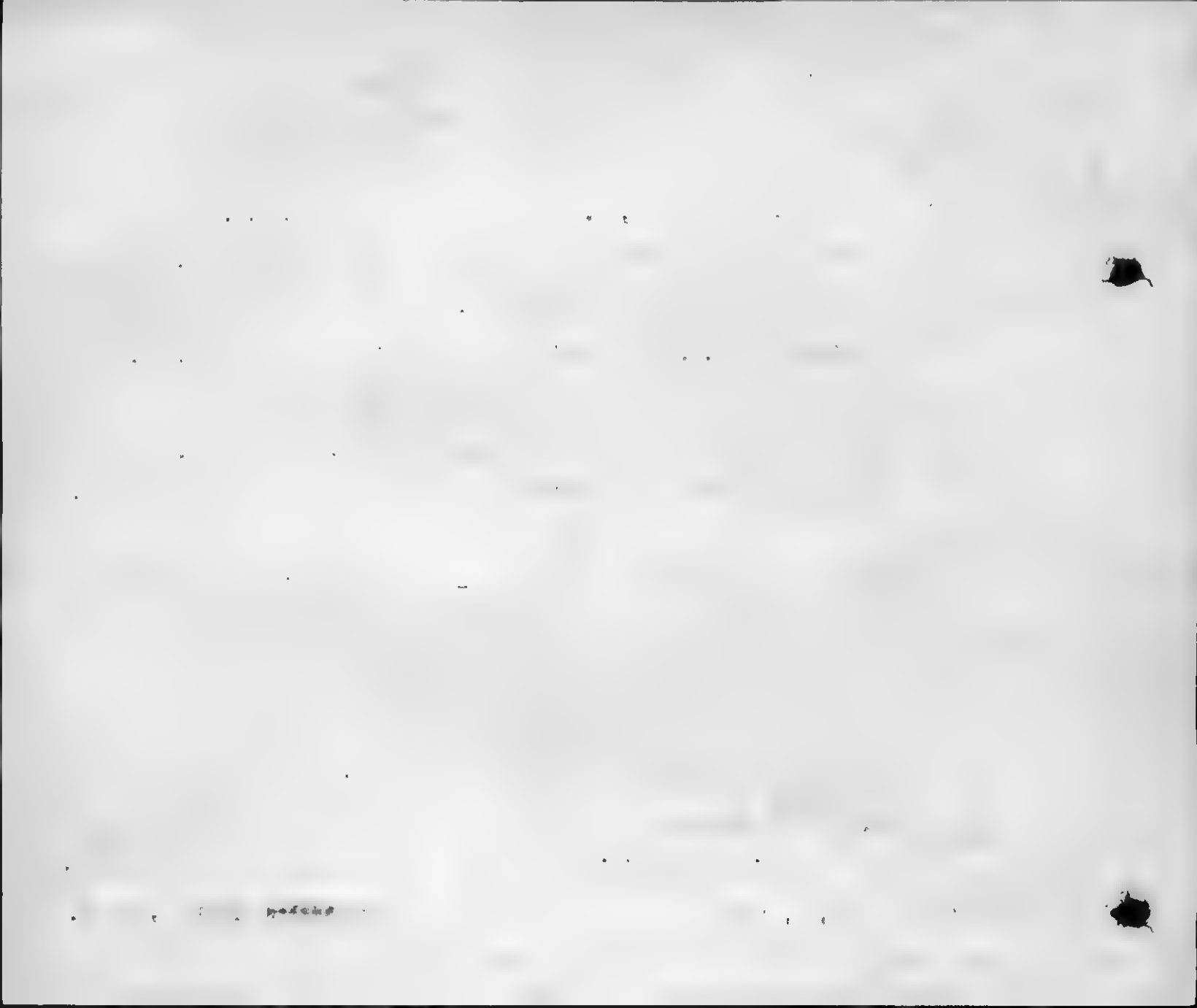
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| 1. PLACE OF DEATH  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  |                                  |
|--|--|--|----------------------------------|
| a. COUNTY  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | a. STATE   | b. COUNTY                        |
| Montgomery   | Bethesda   | Washington   | District Of Columbia             |
| c. LENGTH OF STAY IN 1b<br>37 days   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>3236 Prospect Street, N.W.   |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>The Clinical Center, Bethesda 14, Md.                              |  | d. STREET ADDRESS  |                                  |
| 3. NAME OF DECEASED (Type or print)<br>Mary Carolyn Latimer  |  | 4. DATE OF DEATH<br>December 7, 1961   |                                  |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  | 8. DATE OF BIRTH<br>May 25, 1929 |
| 9. AGE (In years last birthday)<br>32 yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Legislative Assistant                               |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Government   |                                  |
| 11. BIRTHPLACE (County & State, or foreign country)<br>Missouri  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                                  |
| 13. FATHER'S NAME<br>Carl Ernest Ames  |  | 14. MOTHER'S MAIDEN NAME<br>Dorothy Banfield   |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>NO                                      |  | 16. SOCIAL SECURITY NO.<br>Unascertainable   |                                  |
| 17. INFORMANT<br>The Medical Records   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |                                  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Ventricular Fibrillation   |  | INTERVAL BETWEEN ONSET AND DEATH<br>1 min.   |                                  |
| DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | (b) Pulmonary Embolus  |                                  |
| DUE TO<br>(c) Congenital or Rheumatic Heart Disease - Aortic Stenosis  |  | 5 min.   |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                  |  | 31 years   |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br>19  |                                  |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  |
| 20f. (City or town) (County) (State)   |  | 21. I certify that (1) (this hospital) attended the deceased from October 31, 1961 to December 7, 1961 that (1) (we) last saw the deceased alive on December 7, 1961, and that death occurred at 3:50 PM from the causes and on the date stated above. |                                  |
| 22a. SIGNATURE<br>Kenneth L. Melmon  |  | 22b. DATE SIGNED<br>December 8, 1961   |                                  |
| 22c. PHYSICIAN'S NAME (Type)<br>Kenneth L. Melmon, M.D.  |  | 22d. ADDRESS<br>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.   |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE THEREOF<br>Dec. 8, 1961  |                                  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Los Angeles  |  | 23d. LOCATION (City, town or county) (State)<br>Los Angeles, Calif.  |                                  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>Wm T. Antone   |  | 25a. REC'D BY REGISTRAR<br>DEC 11 1961   |                                  |
| 25b. REGISTRAR'S SIGNATURE<br>Wm T. Antone   |  | 25c. DATE  |                                  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

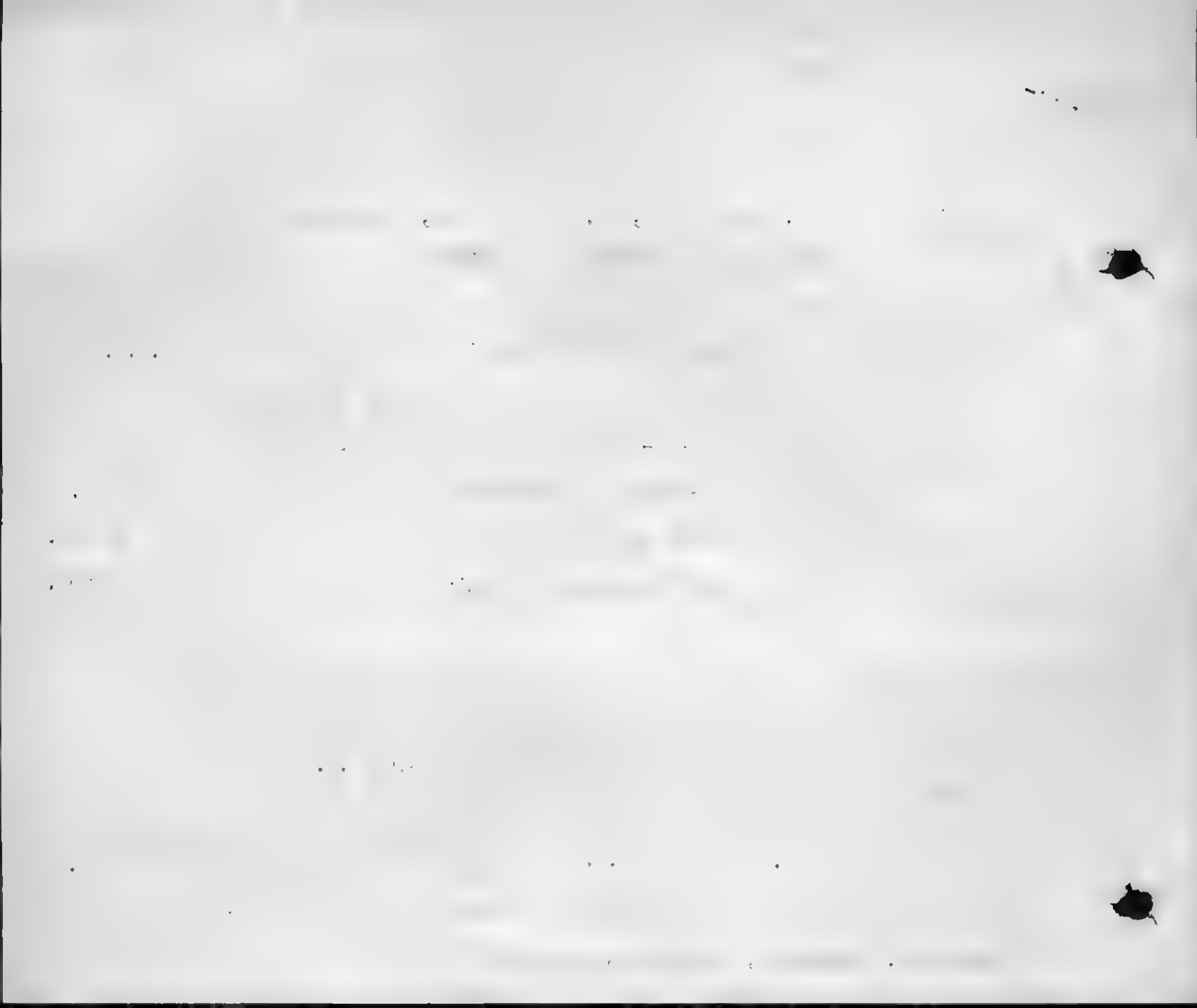
VR A15 (4)  
15M 9/60

14152

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14121

|  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|---|--|--|--|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>  |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b> |  | c. LENGTH OF STAY IN 1b<br><b>15 days</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Virginia</b> |  | b. COUNTY<br><b>Campbell</b>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Lynchburg</b>  |  | d. STREET ADDRESS<br><b>Route #1, Lemon Drive</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>The Clinical Center, Bethesda 14, Md.</b>   |  | 3. NAME OF DECEASED<br>(Type or print)<br><b>KENNETH EUGENE LAYNE</b>                               |  | 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>12 June 1943</b>   |  | 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.<br>last birthday) Months Days Hours Min.<br><b>18 yrs</b> |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student Clerk</b> |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>                      |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |
| 13. FATHER'S NAME<br><b>James Layne</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Elsie Dodson</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b> |  | 16. SOCIAL SECURITY NO.<br><b>227-54-5827</b>  |  | 17. INFORMANT<br><b>The Medical Record</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><b>Intracranial Hemorrhage</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO<br><b>Urate Nephropathy</b><br><b>Acute Lymphocyte Leukemia</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>1 hr.</b><br><b>24 hrs.</b><br><b>10 mos.</b> |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)         |  | 20c. TIME OF INJURY<br>Hour a.m. p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>            |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)<br><b>Lynchburg</b>   |  | 20g. (County)<br><b>Virginia</b>  |  | 20h. (State)<br><b>Virginia</b>  |  |   |  |   |  |
| 21. I certify that <b>10</b> (this hospital) attended the deceased from <b>November 27, 1961</b> to <b>December 12, 1961</b> , that <b>11</b> (we) last saw the deceased alive on <b>December 12, 1961</b> , and that death occurred at <b>3:40 a.m.</b> from the causes and on the date stated above. |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Edward S. Henderson</b> M.D.<br>22c. PHYSICIAN'S NAME (Type)<br><b>EDWARD S. HENDERSON, M.D.</b>  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  | 22b. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b> |  | 22d. DATE<br><b>12/12/61</b>                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial-Transit</b>   |  | 23b. DATE THEREOF<br><b>12/12/61</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Spring Hill Cemetery</b>   |  | 23d. LOCATION (City, town or county)<br><b>Lynchburg, Virginia</b>   |  | 23e. (State)<br><b>Virginia</b>  |  | 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DEC 15 '61</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>C. L. S. K...</b>   |  |   |  |   |  |





14153

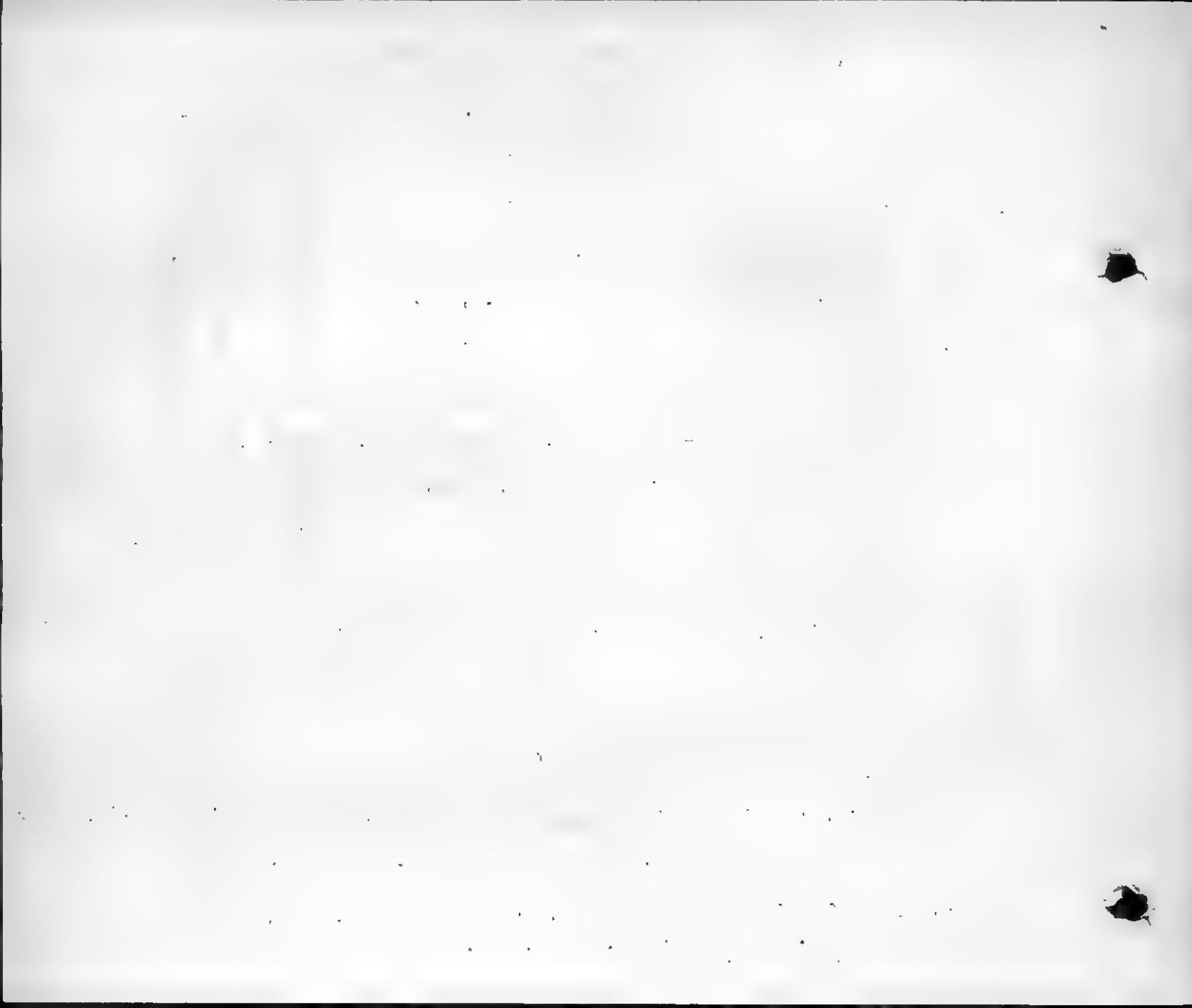
## CERTIFICATE OF DEATH

Reg. Dist. No. 11122

|  |                               |  |                                       |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>             |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Potomac</b>   |                               | c. LENGTH OF STAY IN 1b<br><b>Rockville</b>  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Ropine Nursing Home</b>   |                               | d. STREET ADDRESS<br><b>715 Marshall Avenue</b>  |                                       |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                       |
| 3. NAME OF DECEASED (Type or print) <b>LOUIS</b> First <b>(NMI)</b> Middle <b>LEIBROCK</b> Last  |                               | 4. DATE OF DEATH <b>December 15,</b> 1961<br>Month Day Year  |                                       |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Sept. 7, 1880</b> |
| 9. AGE (In years last birthday) <b>81</b> yrs.   |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret.</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Machenist</b>   |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>Germany</b>  |                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                       |
| 13. FATHER'S NAME<br><b>Unknown</b>  |                               | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <b>272-03-2602</b>   |                                       |
| 17. INFORMANT <b>Mrs <del>Ann L. Welsh</del> Ann L. Welsh - Item # 2</b>   |                               | Address  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA - (RENAL AZOTEMIA)</b> <b>593X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>HYPERTENSIVE ARTERIO-SCLEROTIC HEART DISEASE</b> DUE TO<br>(c) <b>CHRONIC RENAL FAILURE</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>14 DAYS</b><br><b>20 years</b> |                               |  |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>OLD FRACTURE RIGHT HIP - PNEUMONIA</b>  |                               |  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that I attended the deceased from <b>Sept. 27, 1961</b> to <b>Dec. 16, 1961</b> , that I last saw the deceased alive on <b>December 15, 1961</b> , and that death occurred at <b>9:55 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>210 W. Montgomery Ave.,</b> DATE SIGNED <b>Dec. 13, 1961</b>  |                               |  |                                       |
| ACTUAL SIGNATURE <b>Gordon S. Rosenberger</b> M.D.   |                               | 21b. SIGNATURE   |                                       |
| PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger,</b>  |                               | Rockville, Maryland  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Bur-transit</b>  |                               | 22b. DATE THEREOF<br><b>12/15/61</b>   |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>The West Part Cemetery</b>  |                               | 22d. LOCATION (City, town, or county) (State)<br><b>Cleveland, Ohio</b>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Tyson Wheeler Funeral Home-1331 E. Montg. Ave.</b><br>Rockville, Maryland   |                               | 24a. REC'D BY REGISTRAR<br><b>DEC 18 '61</b>   |                                       |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>   |                               |  |                                       |

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Image 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH   |                               |  |                                     |
|---|-------------------------------|--|-------------------------------------|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |                               |  |                                     |
| 14154 Item 8 Film 4503-12/21/61 iwk 14123   |                               |  |                                     |
| 1. PLACE OF DEATH   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution, give name of institution)  |                                     |
| a. COUNTY <b>Montgomery</b>   |                               | a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>   |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>  |                                     |
| c. LENGTH OF STAY IN b. <b>6 days</b>   |                               | d. STREET ADDRESS <b>1</b>   |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General</b>  |                               |  |                                     |
| 3. NAME OF DECEASED (Type or print)   |                               | 4. DATE OF DEATH   |                                     |
| First Middle Last <b>Wade Hamilton Leizear</b>  |                               | Month Day Year <b>12 11 1961</b>   |                                     |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>6/3/80</b> 1880 |
| 9. AGE (In years, months, days) <b>81</b> yrs. <b>12</b> months <b>11</b> days  |                               | 10. AGE (In years, months, days) <b>81</b> yrs. <b>12</b> months <b>11</b> days  |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>  |                                     |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Montg. Co., Md.</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                                     |
| 13. FATHER'S NAME <b>Samuel Leizear</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Annie Pagett</b>   |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |                               | 16. SOCIAL SECURITY NO. <b>217-14-6652</b>   |                                     |
| 17. INFORMANT <b>Hospital Records</b>   |                               | Address  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for a), b), and c)]   |                               |  |                                     |
| PART I. DEATH WAS CAUSED BY: <b>ACUTE MYOCARDIAL INFARCTION</b>   |                               |  |                                     |
| IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>COMMONARY ATHEROSCLEROSIS</b>  |                               |  |                                     |
| Conditions, if any, which gave rise to immediate cause (b) <b>103</b>   |                               |  |                                     |
| (c) <b>103</b> DUE TO <b>103</b>  |                               |  |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)   |                               |  |                                     |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                               |  |                                     |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)   |                               |  |                                     |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                               |  |                                     |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>   |                               |  |                                     |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                               |  |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               |  |                                     |
| 20f. (City or town) (County) (State)  |                               |  |                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>John</b> , 1957 to <b>Dec</b> , 1961, that (I) (we) last saw the deceased alive on <b>Dec 10</b> , 1961, and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above. |                               |  |                                     |
| 22a. SIGNATURE <b>A.D. Bonifant</b> M.D.  |                               |  |                                     |
| 22b. DATE SIGNED <b>Dec 14 1961</b>   |                               |  |                                     |
| 22c. PHYSICIAN'S NAME (Type) <b>A.D. Bonifant</b>   |                               |  |                                     |
| 22d. ADDRESS <b>Sandy Spring, Md.</b>   |                               |  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               |  |                                     |
| 23b. DATE THEREOF <b>Dec. 14, 1961</b>  |                               |  |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>  |                               |  |                                     |
| 23d. LOCATION (City, town or county) (State) <b>Olney, Md.</b>  |                               |  |                                     |
| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Francis H. Barber Laytonsville, Md.</b>   |                               |  |                                     |
| 25a. REC'D BY REGISTRAR <b>DEC 14 '61</b>   |                               |  |                                     |
| 25b. REGISTRAR'S SIGNATURE <b>John S. Kraus</b>   |                               |  |                                     |

GENERAL ALBRIOS/EROSIS  
HEUTE HYOGARDIN IN FRATERN

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14124

14155

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Olney

c. LENGTH OF STAY (in days)

45 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Montgomery General Hospital

### 3. NAME OF DECEASED

First

Middle

Last

Anna

Magrel

Lifka

### 4. DATE OF DEATH

Month

Day

Year

December 13, 1961

### 5. SEX

female

### 6. COLOR OR RACE

white

### 7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

### 8. DATE OF BIRTH

January 29, 1895

### 9. AGE (in years last birthday)

66 yrs.

### 10. IF UNDER 1 YEAR

Months Days

### 11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

home-making

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Czechoslovakia

12. CITIZEN OF WHAT COUNTRY?

unknown USA

13. FATHER'S NAME

Karl Magrel

14. MOTHER'S MAIDEN NAME

Elizabeth Woiafka

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Hospital records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN ONSET AND DEATH

7 months

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from... Apr. 1961 to 12-13, 1961, that (I) saw the deceased alive on 12-13, 1961, and that death occurred 6:30 PM, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

JACK SCHUMACHER, M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

12-15-61

22d. ADDRESS

GAITHERSBURG, MARYLAND

23a. BURIAL, CREMATION, 23b. DATE THEREOF

Burial

Dec. 16 1961

23c. NAME OF CEMETERY OR CREMATORY

Gate Of Heaven

23d. LOCATION (City, town or county)

Silver Spring

Md.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Francis H. Barber

Laytonsville, Md.

DEC 18 '61

Arthur S. Kline

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14156

14125

STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|   |                               |  |                                   |   |   |   |                               |
|---|-------------------------------|--|-----------------------------------|---|---|---|-------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                               |  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Washington DC</u> b. COUNTY <u>✓</u> |   |   |                               |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda - 9200 Wisconsin</u> c. LENGTH OF STAY IN 1b <u>18 months</u>  |                               |  |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4125</u>  |   |   |                               |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Sanitarium</u>  |                               |  |                                   | d. STREET ADDRESS <u>825 New Hampshire Ave NW</u>   |   |   |                               |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last <u>HANNA ANDERSON LINDSTROM</u>  |                               |  |                                   | 4. DATE OF DEATH<br>Month Day Year <u>12 30 1961</u>  |   |   |                               |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/15/1887</u> | 9. AGE (In years last birthday) <u>74</u> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>   |                                   | 11. BIRTHPLACE (State or foreign country) <u>SWEDEN</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>    |                               |
| 13. FATHER'S NAME <u>ANDREA ANDERSON</u>  |                               |  |                                   | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>   |   |   |                               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |                               | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u>   |                                   | 17. INFORMANT Address <u>HAROLD LINDSTROM (son) 825 New Hampshire Ave NW</u>  |   |   |                               |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <u>CONGESTIVE HEART FAILURE</u><br>(c) <u>CORONARY ARTERY DISEASE</u> |                               |  |                                   |   |   |   |                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS</u>   |                               |  |                                   |   |   |   |                               |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |                                   |   |   |   |                               |
| 20c. TIME OF INJURY Month. Day. Year<br>Hour a. m. p. m. <u>19</u>  |                               | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)          |                               |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>60</u> to <u>Dec.</u> 19 <u>61</u> . That (I) (we) last saw the deceased alive on <u>12/30</u> 19 <u>61</u> , and that death occurred at <u>10:25</u> PM, from the causes and on the date stated above.  |                               |  |                                   |   |   |   |                               |
| 22a. SIGNATURE <u>Robert F. Dyer</u> M. D.  |                               |  |                                   | 22b. DATE SIGNED  |   |   |                               |
| 22c. PHYSICIAN'S NAME (Type) <u>ROBERT F. DYER, M.D.</u>  |                               |  |                                   | 22d. ADDRESS <u>915 19th St. N.W. Wash, D.C.</u>  |   |   |                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                               | 23b. DATE THEREOF <u>1/6/62</u>  |                                   | 23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET MEMO. PARK MINNEAPOLIS, MINN.</u>  |   | 23d. LOCATION (City, town, or county) (State) |                               |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u> ADDRESS <u>P.O. 3072 Mt St NW Wash DC</u>  |                               |  |                                   | 25a. REC'D BY REGISTRAR <u>DATE JAN 4 '62</u>   |   | 25b. REGISTRAR'S SIGNATURE <u>C. J. ...</u>   |                               |





HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14157 13 & 14 Film G304 1/2/62 iwk 14126

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda  
c. LENGTH OF STAY IN 1b 7 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban

2. USUAL RESIDENCE (Where decedent lived, if institution; Residence before admission)  
a. STATE MD b. COUNTY MONTGOMERY  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wheaton  
d. STREET ADDRESS 1211 Valley wood Dr.  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)  
First Middle Last  
Caroline Locken  
4. DATE OF DEATH Month Day Year  
Dec. 25 1961

5. SEX female 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH  
May 14, 1910 9. AGE (In years last birthday) 51 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  
7 11

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper 10b. KIND OF BUSINESS OR INDUSTRY private 11. BIRTHPLACE, County & State, or foreign country South Dakota 12. CITIZEN OF WHAT COUNTRY U. S.

13. FATHER'S NAME unknown 14. MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Suburban Hosp. Records. Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Acute peritonitis  
DUE TO (b) leakage, anastomotic site  
DUE TO (c) Obstruction small intestine, status postoperative  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral atelectasis with pulmonary edema

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐  
INTERVAL BETWEEN ONSET AND DEATH  
1 Day  
1 Day  
6 Days

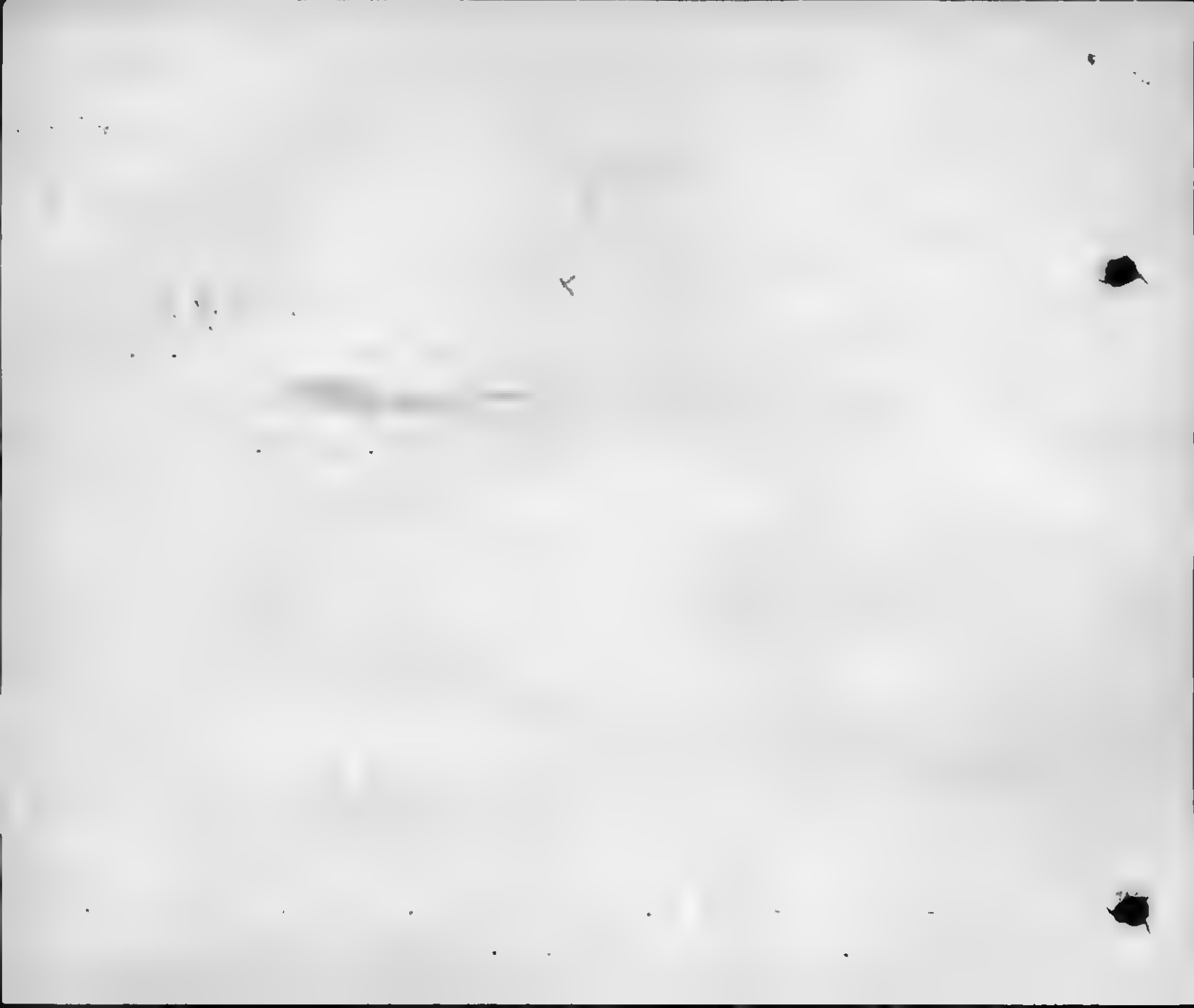
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 12/18 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City or town (County) (State)

21. I certify that (I) this hospital attended the deceased from 12/18 to 12/25, 1961, that (I) was last saw the deceased alive on 12/25, 1961, and that death occurred at 4:55 PM, from the causes and on the date stated above.

22a. SIGNATURE Frederick Y. Donn M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 12/26/61  
22c. PHYSICIAN'S NAME (Type) Frederick Y. Donn 22d. ADDRESS 1835 I St., N.W. Wash. DC

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 23b. DATE THEREOF 12-27-61 23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem. 23d. LOCATION (City, town or county) (State) Dimock, South Dakota.

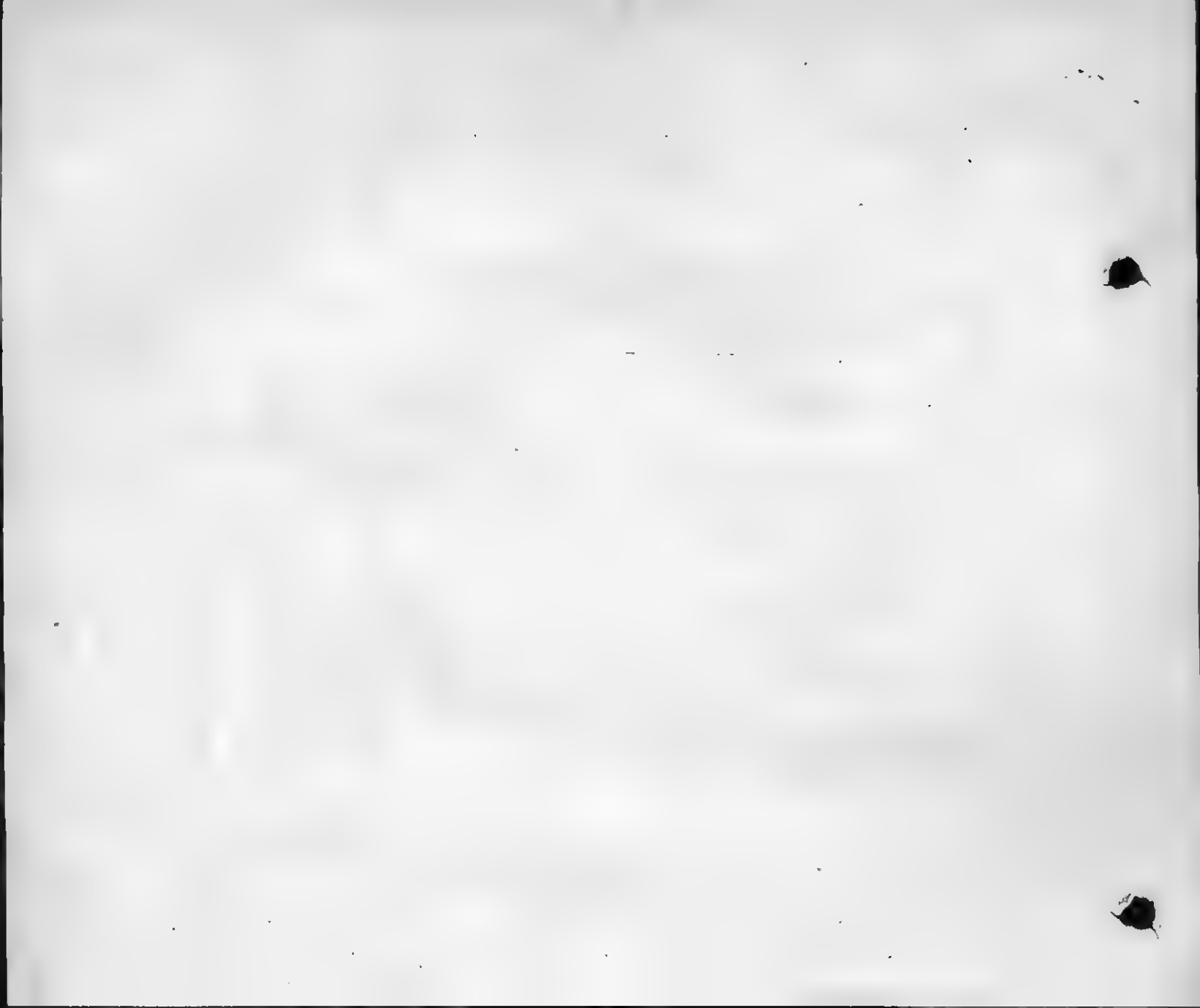
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Md. 25a. REC'D BY REGISTRAR DEC 28 '61 25b. REGISTRAR'S SIGNATURE Christina S. Harris



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|--|--|---|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |  |  |  |  |   |
| 14158 Item 1 Film G304 1/4/62 iwk 14127   |  |  |  |  |  |  |  |  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                  |  |  |  |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  |  | c. LENGTH OF STAY IN Td<br><u>DOA</u>  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Suburban Hosp. (died enroute to Hosp.)</u><br><u>5609 Johnson Avenue</u>   |  |  | d. STREET ADDRESS<br><u>5609 Johnson Avenue</u>  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br><u>Mary</u>  |  |  | 4. DATE OF DEATH<br><u>December 28</u> 19 <u>61</u>  |  |  |  |  |  |   |
| 5. SEX<br><u>Female</u>   |  |  | 6. COLOR OR RACE<br><u>White</u>   |  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |   |
| 8. DATE OF BIRTH<br><u>8/11/1878</u>  |  |  | 9. AGE (In years last birthday)<br><u>83</u> yrs.  |  |  | 10. IF UNDER 1 YEAR Months <u>4</u> Days <u>17</u>   |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)<br><u>Housewife</u>  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>-----</u>  |  |  | 11. BIRTHPLACE (County & State or foreign country)<br><u>Kentucky</u>  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                              |
| 13. FATHER'S NAME<br><u>Luke Allen Howland</u>  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>(Unknown) Perkins</u>   |  |  |  |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><u>No</u>   |  |  | 16. SOCIAL SECURITY NO.<br><u>None</u>   |  |  | 17. INFORMANT<br><u>Mrs. James Davis-Daughter-same 2d</u>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u><br>(c), stating the underlying cause last. DUE TO <u>Generalized Arteriosclerosis</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>-----</u>   |  |  |  |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)   |  |  |  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>-----</u> e.m. <u>-----</u> p.m. <u>19</u>  |  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  | 20f. (City or town) (County) (State)                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5/11/1959</u> to <u>2/28/1961</u> , that (I) (we) last saw the deceased alive on <u>12/28/1961</u> , and that death occurred at <u>1:15 PM</u> from the causes and on the date stated above.   |  |  |  |  |  |  |  |  |   |
| 22a. SIGNATURE<br><u>W. T. Joyce</u>  |  |  | 22b. DATE SIGNED<br><u>1/28/61</u>   |  |  |  |  |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>W. T. Joyce</u>  |  |  | 22d. ADDRESS<br><u>8106 Maple Ridge Rd., Bethesda, Md.</u>   |  |  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial-Transit 1/2/62</u>   |  |  | 23b. DATE THEREOF<br><u>1/2/62</u>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Howland Cemetery</u>  |  |  | 23d. LOCATION (City, town or county) (State)<br><u>Quincy, Kentucky</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey, Bethesda, Maryland</u>   |  |  | 25a. REC'D BY REGISTRAR<br><u>Arthur S. Hanna</u>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>-----</u>   |  |  | DATE<br><u>JAN 2 '62</u>  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14159

14128

### PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Wheaton

c. LENGTH OF STAY IN

3 1/2 Mo.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Wheaton Nursing Home

3. NAME OF DECEASED  
(Type or print)

First

Maude

Middle

Vernon

Last

Long

4. DATE OF DEATH

Month

12

Day

1

Year

1961

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

12/2/1880

9. AGE (In years last birthday)

80 yrs

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Pt. Republic, Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Franklin Hudlow

14. MOTHER'S MAIDEN NAME

Lucy Michael

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Address

Nursing Home Records- Wheaton, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Carcinomatosis

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Carcinoma R. Breast-metastatic

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

6yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).

arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour a.m.  
p.m.

20d. INJURY OCCURRED  
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 18 Nov 1961 to 1 Dec 1961 that (I) (we) last saw the deceased alive on 27 Nov 1961, and that death occurred at 12:30 PM from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Ira N. Tublin

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

22d. ADDRESS

25 E. Wayne Ave.

Silver Spring

Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

burial

23b. DATE THEREOF

12/4/61

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

23d. LOCATION (City, town or county)

Suitland, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

The S.H. Hines Co. Washington 9, D.C.

25a. REC'D BY REGISTRAR

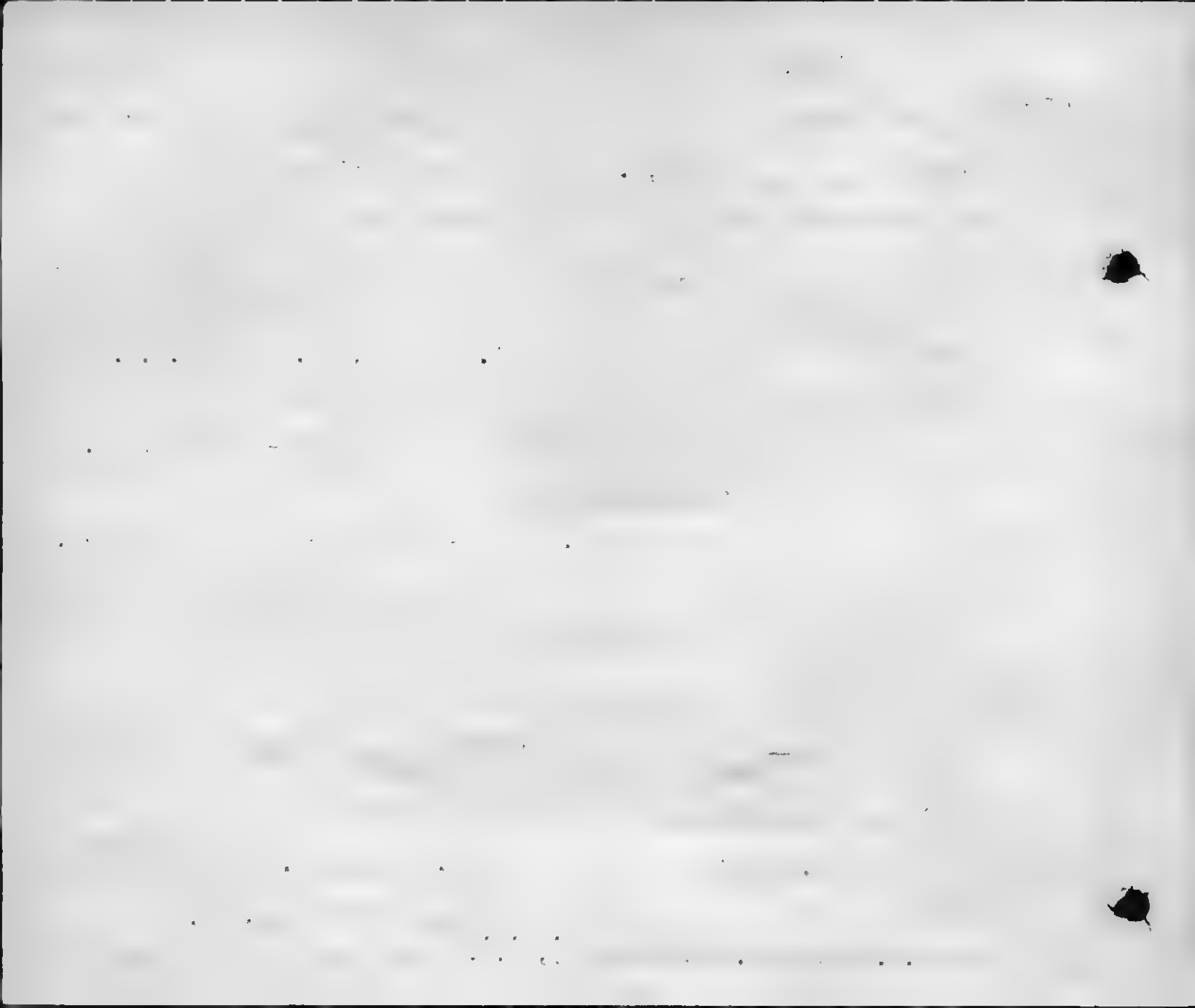
DEC 4 '61

25b. REGISTRAR'S SIGNATURE

C. L. Hines

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death.

1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

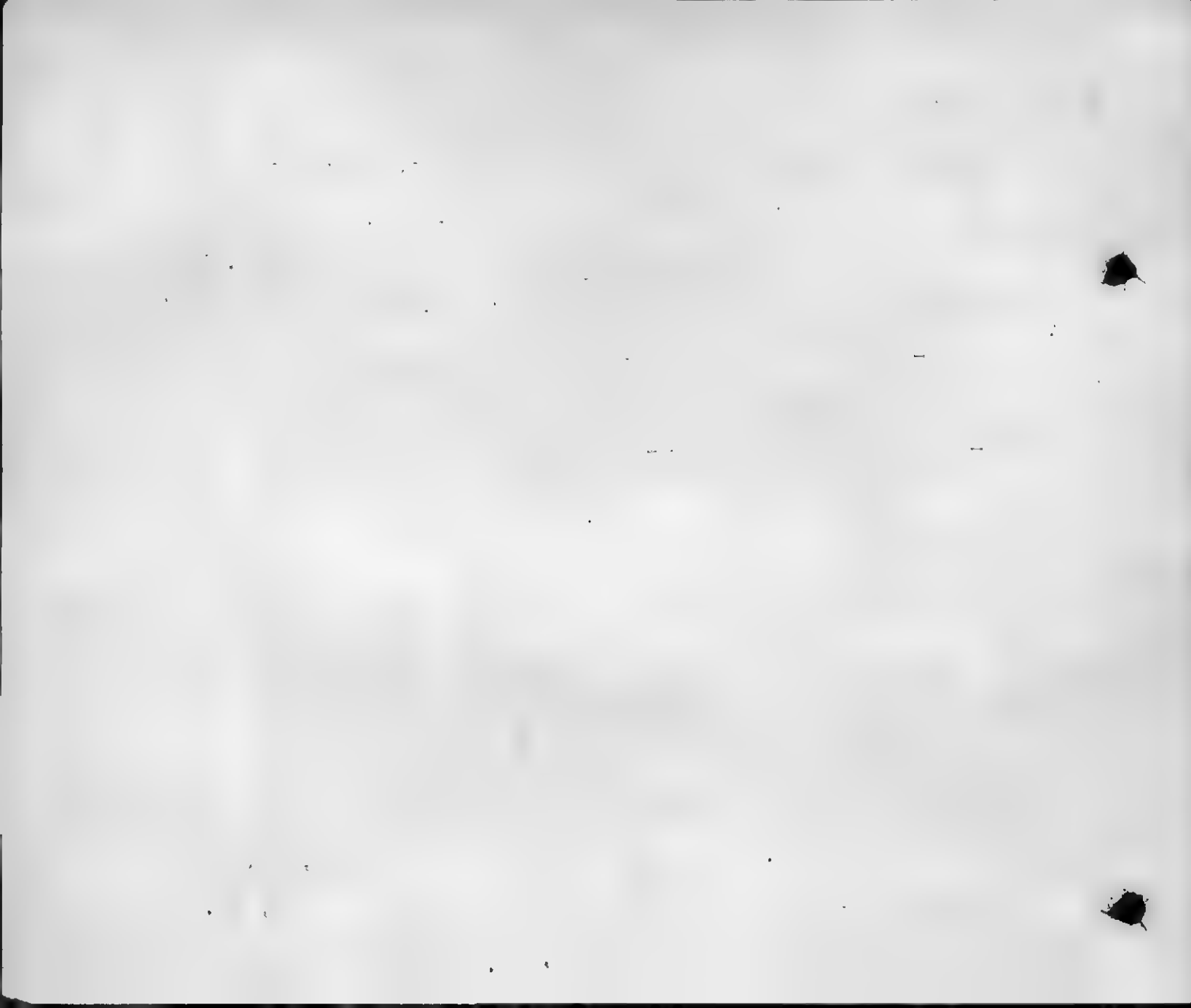
14160

14129

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural- Lewisdale</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RFD # 1, Monrovia</u>                         |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Rural- Lewisdale</u><br>d. STREET ADDRESS <u>RFD # 1, Monrovia</u>  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><u>Tywana Renae Lyles</u>   |  |  | <b>4. DATE OF DEATH</b><br><u>Dec. 1 19 61</u>  |  |  |
| <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Colored</u>  |  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>March 24, 1961</u>  |  |  |
| <b>9. AGE</b> (In years, last birthday) <u>8</u> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>  |  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Frederick, Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>  |  |  |
| <b>13. FATHER'S NAME</b> <u>George Lyles</u>  |  |  | <b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Dyson</u>   |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>None</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>George Lyles, Item 2</u>  |  |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchial asthma</u><br>DUE TO (b) <u>Acute tracheobronchitis</u><br>DUE TO (c) <u>None</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | <b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 days</u>   |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <u>None</u>   |  |  | <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |  |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>None</u> <b>20f. (City or town)</b> <u>Damascus, Md.</u>   |  |  | <b>20g. (County)</b> <u>Damascus, Md.</u> <b>20h. (State)</b> <u>Md.</u>  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12/1/61</u> <b>19</b> <u>61</u> , <b>to</b> <u>12/1/61</u> , <b>19</b> <u>61</u> , <b>that (I) (the) last saw the deceased alive on</b> <u>12/1/61</u> , <b>and that death occurred at</b> <u>10:00 P.M.</u> , <b>from the causes and on the date stated above.</b> |  |  |   |  |  |
| <b>22a. SIGNATURE</b> <u>James P. Kerr</u> <b>22b. DATE SIGNED</b> <u>12/1/61</u>   |  |  | <b>22c. PHYSICIAN'S NAME (Type)</b> <u>James P. Kerr</u> <b>22d. ADDRESS</b> <u>Damascus, Md.</u>   |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>12/3/61</u>  |  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Pleasant Grove</u> <b>23d. LOCATION (City, town or county)</b> <u>Purdum, Md.</u>  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John L. N. Smith</u>   |  |  | <b>25a. REC'D BY REGISTRAR</b> <u>DEC 5 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>John L. N. Smith</u>   |  |  |

2069304-XV1

VR A15 (4)  
15M 9/60





CERTIFICATE OF DEATH

Reg. Dist. No. 14130

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE _____ b. COUNTY _____                                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington - D.C.</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brocke Grove Foundation</u>  |   | d. STREET ADDRESS <u>3825 Legation St., N.W.</u>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>C.</u> Last <u>Macatee</u>   |   | 4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1961</u>  |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 28 - 1878</u>                               |
| 9. AGE (In years last birthday) <u>83</u> yrs  |   | IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS Hours _____ Min _____  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Christ. Science Practitioner</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY _____  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Mobile Bay, Alabama</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>   |  |
| 13. FATHER'S NAME <u>Robinson B. Murphy</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Lina Doran</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____  |   | 16. SOCIAL SECURITY NO _____   |  |
| 17. INFORMANT <u>Hospital Records</u>  |   | Address _____  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u><br>DUE TO (b) <u>Hypertensive C-V Disease</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u><br><u>YES</u>          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____  | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____   | 20f. (City or town) _____ (County) _____ (State) _____               |
| 21. I certify that I attended the deceased from <u>11-22-</u> 19 <u>61</u> , to <u>12-22-1961</u> , that I last saw the deceased alive on <u>12-19-1961</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.   |   |  |  |
| ACTUARY SIGNATURE <u>C.H. Ligon</u>  |   | DATE SIGNED <u>12/22/61</u>  |  |
| PHYSICIAN'S NAME (Type) _____  |   | ADDRESS (Street, city or town, state) <u>5045 Spring</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>   | 22b. DATE THEREOF <u>12/27/61</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Fairview - 1st Cem.</u>  | 22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>  |   | 24a. REC'D BY REGISTRAR <u>DEC 26 '61</u>  |  |
| ADDRESS <u>5103 Washington</u>   |   | 24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1  
be retained by the attending physician and completed and filed in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14162

Item 25c, Film G304 1/3/62 iwk

14131

|  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>  |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b> |  | c. LENGTH OF STAY IN TB<br><b>1 day</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b> |  | b. COUNTY<br><b>Silver Springs</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>8305 12th Avenue</b>  |  | d. STREET ADDRESS<br><b>8305 12th Avenue</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Janet Mary MacLean</b>  |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>28</b> Year <b>1961</b>                                    |  | 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>Caucasian</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>March 19, 1901</b>  |  | 9. AGE (In years last birthday)<br><b>60 yrs</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Inverness, Scotland</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>England</b> |  |
| 13. FATHER'S NAME<br><b>Thomas Perry</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Monroe</b>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b> |  | 16. SOCIAL SECURITY NO.<br><b>---</b>  |  | 17. INFORMANT<br><b>DAUGH: Mrs. Margaret Asher, Same as #2</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO <b>4-20-61</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic heart disease</b><br>DUE TO <b>4-20-61</b><br>cause listed (c) <b>4-20-61</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>hours</b><br><b>years</b>                                  |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)                 |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>19</b> e.m. <b>19</b> p.m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>            |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |  |  |
| 21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>Dec. 28, 1961</b> , to <b>Dec. 28, 1961</b> that <b>(X)</b> (we) last saw the deceased alive on <b>Dec. 28, 1961</b> and that death occurred <b>11:55 AM</b> from the causes and on the date stated above |  | 22a. SIGNATURE<br><b>Robert E. DeForest</b>   |  | 22b. DATE SIGNED<br><b>December 28, 1961</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>ROBERT E. DEFOREST LT MC USN</b>  |  | 22d. ADDRESS<br><b>U. S. Naval Hospital, Bethesda, Maryland</b>  |  | 22e. REC'D BY REGISTRAR<br><b>January 2 '62</b>  |  | 22f. REGISTRAR'S SIGNATURE<br><b>Wm. S. Finner</b>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>1-2-62</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>George Washington Cem. Park Lawn Cemetery</b>                               |  | 23d. LOCATION (City, town or county) (State)<br><b>P.G. County, Rockville, Maryland</b>                              |  | 23e. ADDRESS<br><b>S.S., Md.</b>   |  | 23f. DATE<br><b>Jan 2 '62</b>  |  | 23g. REGISTRAR'S SIGNATURE<br><b>Wm. S. Finner</b>  |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Warner Humphrey</b>   |  | 24b. ADDRESS<br><b>8434 Ga. Ave.</b>  |  | 24c. DATE<br><b>Jan 2 '62</b>  |  | 24d. REGISTRAR'S SIGNATURE<br><b>Wm. S. Finner</b>   |  | 24e. ADDRESS<br><b>8434 Ga. Ave.</b>   |  | 24f. DATE<br><b>Jan 2 '62</b>  |  | 24g. REGISTRAR'S SIGNATURE<br><b>Wm. S. Finner</b>  |  |  |  |   |  |  |  |

*[Faint handwritten notes]*

6. 1981-1982

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4 5 6

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

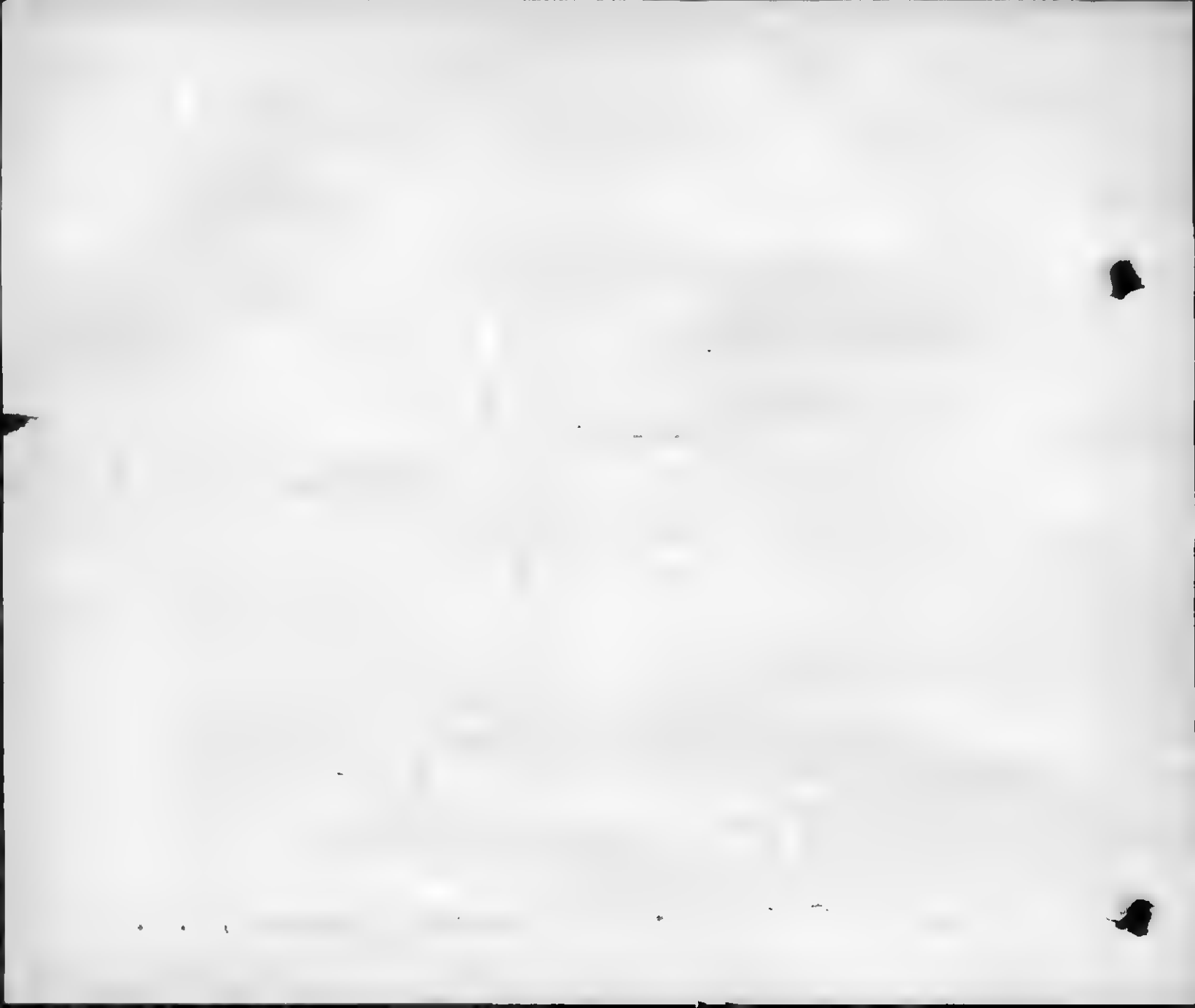
14163

**CERTIFICATE OF DEATH**

14132

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission)<br>a. STATE <b>Virginia</b> COUNTY <b>FAIRFAX</b>                      |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>   |  |   |  | c. LENGTH OF STAY IN lb<br><b>13 days</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Kensington Gardens Sanitarium</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>George</b> Middle <b>Perrin</b> Last <b>Mangan</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>11</b> Year <b>19 61</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. CO. OR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Feb. 8, 1877</b>                                   |  |
| 9. AGE (In years last birthday)<br><b>84</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <b>84</b> Days <b>84</b> Hours <b>84</b> Min <b>84</b>                      |  | 11. IF UNDER 24 HRS<br>Months <b>84</b> Days <b>84</b> Hours <b>84</b> Min <b>84</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Executive</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Potomac Electric Co.</b>  |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Richmond, Va.</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |
| 13. FATHER'S NAME<br><b>Joseph T. Mangan</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Nora Perrin</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><input type="checkbox"/>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>577-09-3690</b>   |  |   |  |
| 17. INFORMANT<br><b>ROSA MANGAN KIRBY</b>   |  |   |  | Address <b>McLean, Va. 4410 Chesterbrook Rd.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>450.8 Cardiac Failure</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Insanition</b><br>(c) <b>Arteriosclerosis</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b><br><b>20+ yrs.</b> |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month. <b>12</b> Day. <b>11</b> Year <b>19 61</b><br>Hour a. m. <b>11:00</b> p. m. <b>11:00</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                      |  |
| 21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1940</b> to <b>12/11/61</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>12-17-61</b> , and that death occurred on <b>12-11-61</b> at <b>11:00</b> M, from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>E. H. Aschenbach</b>   |  |   |  | 22b. DATE SIGNED<br><b>12/11/61</b>   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>E. H. Aschenbach</b>   |  |   |  | 22d. ADDRESS<br><b>1841 Col Rd NW</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>12-14-1961</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Washington, D. C.</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph J. ...</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>1756 ...</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. To be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

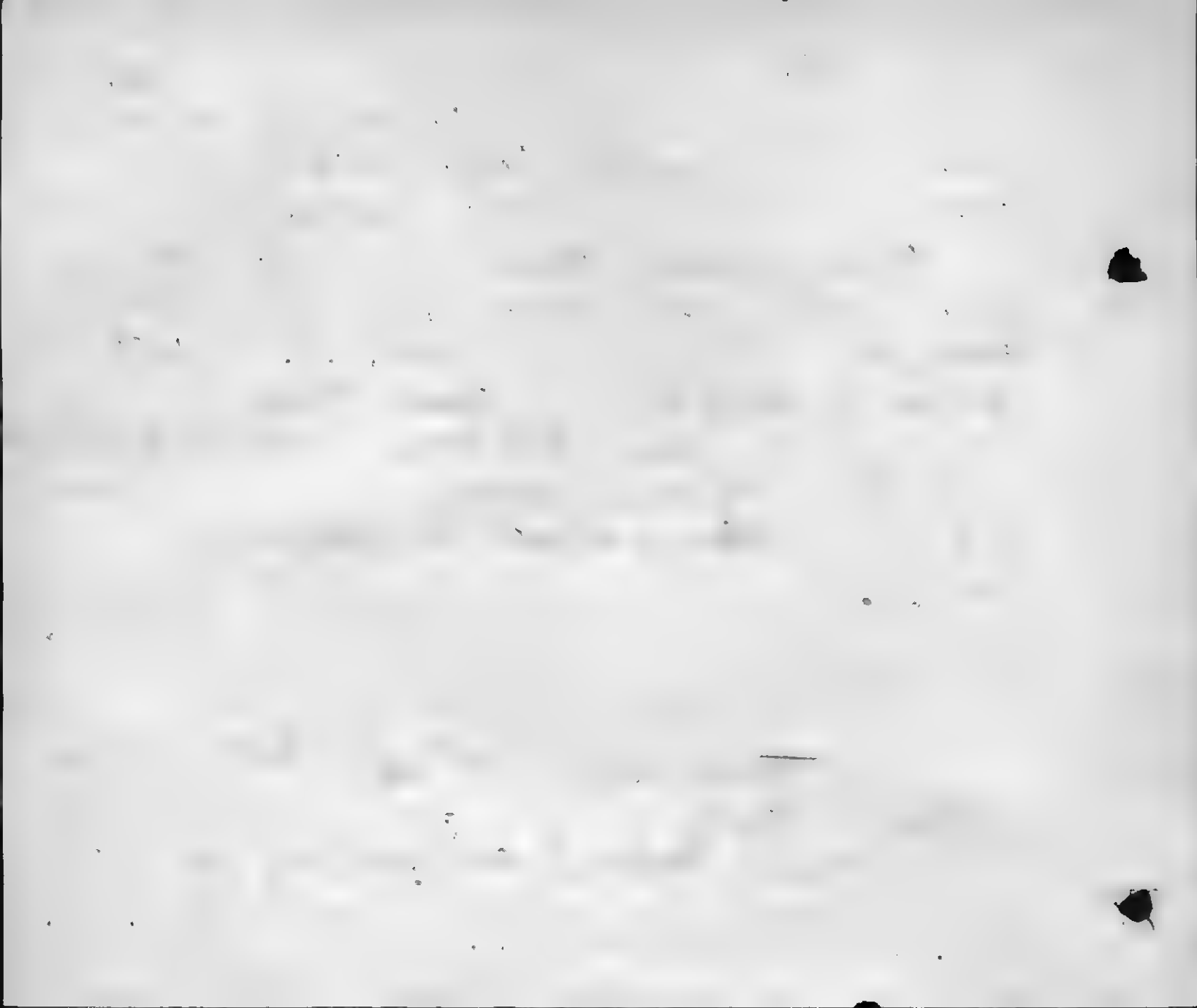
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14164

14133

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <u>Yorktown Village</u><br>c. LENGTH OF STAY IN <u>MARYLAND</u> <u>22 YEARS</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5021 Worthington Drive</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence Before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <u>Yorktown Village</u><br>d. STREET ADDRESS <u>5021 Worthington Drive</u><br>e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>MARION CATHERINE MANN</u>   |  | <b>4. DATE OF DEATH</b><br>Month <u>Dec</u> Day <u>27</u> Year <u>1961</u>   |  |
| <b>5. SEX</b> <u>female</u>  |  | <b>6. COLOR OR RACE</b> <u>white</u>   |  |
| <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b> <u>April 29, 1890</u>  |  |
| <b>9. AGE</b> (In years last birthday) <u>71 yrs.</u>  |  | <b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |  |
| <b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>   |  |
| <b>13. FATHER'S NAME</b> <u>William H. Melchior</u>  |  | <b>14. MOTHER'S MAIDEN NAME</b> <u>Grace Steiner</u>   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>   |  | <b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>   |  |
| <b>17. INFORMANT</b> <u>H.W. MANN</u>  |  | <b>18. ADDRESS</b> <u>Yorktown Village, Md. 5021 Worthington Dr.</u>   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause; line for (e), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e) <u>Pulmonary edema</u><br>DUE TO (b) <u>arteriosclerotic heart disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>   |  |  |  |
| <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>  |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>  |  | <b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>  |  |
| <b>21. I certify that (I) (the hospital) attended the deceased from</b> <u>March 1959</u> <b>to</b> <u>Dec 27, 1961</u> , <b>that (I) last saw the deceased alive on</b> <u>Dec 27, 1961</u> , <b>and that death occurred at</b> <u>  </u> , <b>from the causes and on the date stated above.</b>  |  |  |  |
| <b>22a. SIGNATURE</b> <u>Harry N. Carlton</u>  |  | <b>22b. DATE SIGNED</b> <u>  </u>  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b> <u>HARRY N. CARLTON</u>  |  | <b>22d. ADDRESS</b> <u>940-25th St, N.W. Wash D.C.</u>   |  |
| <b>23a. BURIAL, CREMATION REMOVAL (Specify)</b> <u>Burial</u>  |  | <b>23b. DATE THEREOF</b> <u>12/29/61</u>   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>   |  | <b>23d. LOCATION</b> (City, town or county) <u>Prince Georges Co., Md.</u>   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S. H. Hines Company</u>   |  | <b>25. REC'D BY REGISTRAR</b> <u>  </u>  |  |
| <b>25a. ADDRESS</b> <u>Washington, D.C.</u>  |  | <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>   |  |
| <b>DATE</b> <u>DEC 28 '61</u>  |  | <b>DATE</b> <u>DEC 28 '61</u>  |  |





HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

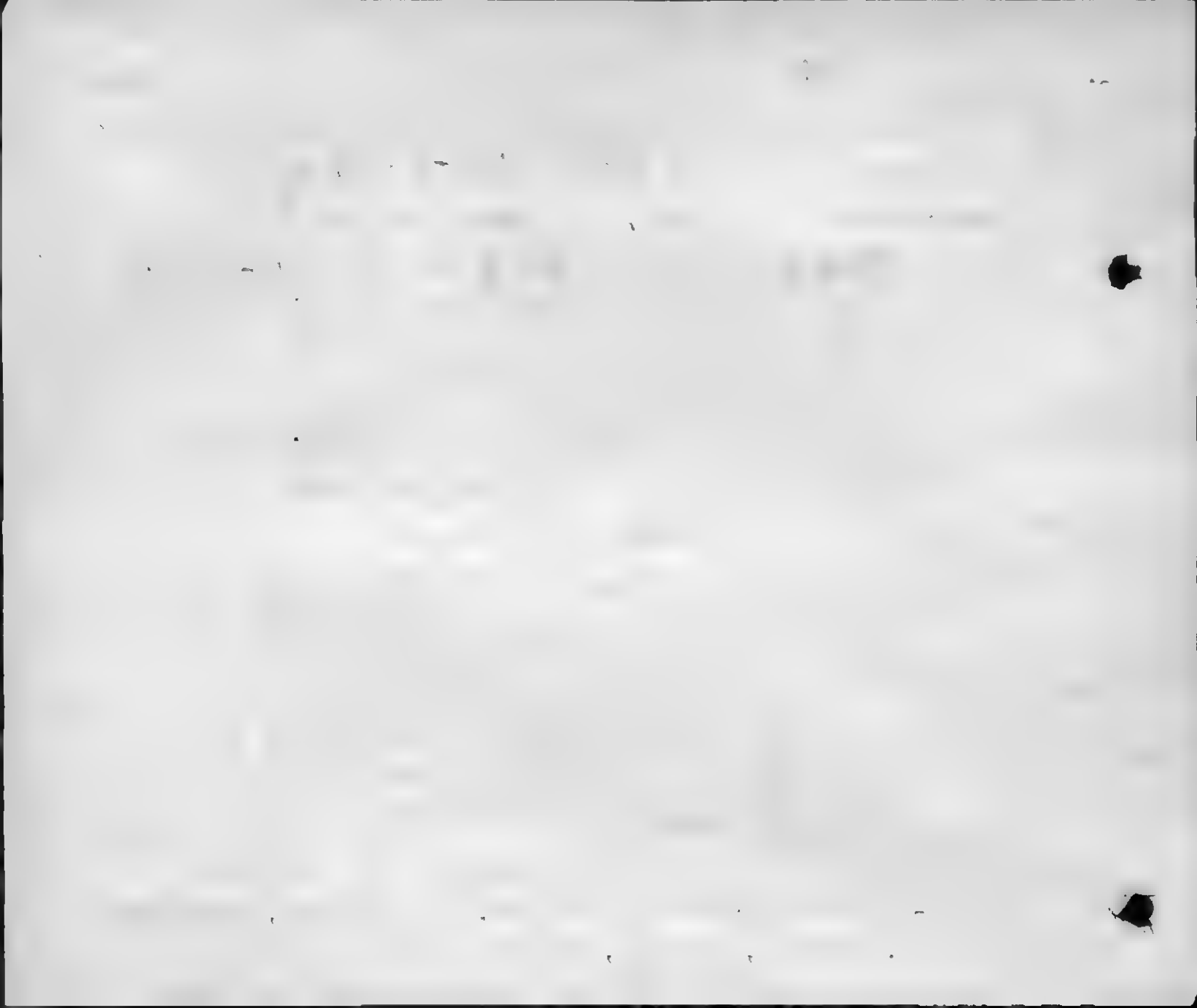
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14165

14134

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b <u>5 hrs</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp.</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Mont.</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>d. STREET ADDRESS <u>10003 Clue Dr.</u>   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Helen L Manno</u><br>First Middle Last<br><b>5. SEX</b> <u>F</u><br><b>6. COLOR OR RACE</b> <u>W</u><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br><b>8. DATE OF DEATH</b> <u>Dec 16 1961</u><br>Month Day Year<br><b>9. AGE</b> (In years last birthday) <u>33</u> yrs.<br><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Chester PA.</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u> |  | <b>13. FATHER'S NAME</b> <u>Fury Oleksey</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u><br><b>16. SOCIAL SECURITY NO.</b> <u>None</u><br><b>17. INFORMANT</b> <u>Joseph R. Manno</u><br>Address <u>Same</u><br><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u><br>Conditions, if any, which gave rise to immediate cause (b) <u>THROMBOCYTOPENIA</u><br>(a), stating the underlying cause last (c) <u>ACUTE MYELOCYTIC LEUKEMIA</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u><br><b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| <b>20a. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u><br><b>20b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20d. (City or town)</b> (County) (State)   |  | <b>21. I certify that (I) (the hospital) attended the deceased from <u>DEC 2, 1961</u> to <u>DEC 16, 1961</u>, that (I) (we) last saw the deceased alive on <u>DEC 16, 1961</u>, and that death occurred at <u>HOME</u>, from the causes and on the date stated above.</b><br><b>22a. SIGNATURE</b> <u>John H. Tuohy</u> M.D.<br><b>22b. PHYSICIAN'S NAME</b> (Type) <u>J. H. TUOHY, M.D.</u><br><b>22c. ADDRESS</b> <u>7720 WISCONSIN AVE BETHESDA MD.</u><br><b>22d. DATE SIGNED</b> <u>12-16-61</u>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial-Transit 12/19/61 Emaculate Cem.</u><br><b>23b. DATE THEREOF</b><br><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Chester, Pennsylvania</u><br><b>23d. LOCATION</b> (City, town or county) (State)  |  | <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u><br><b>25a. REC'D BY REGISTRAR</b> <u>DEC 21 '61</u><br><b>25b. REGISTRAR'S SIGNATURE</b> <u>C. J. S. Frank</u>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

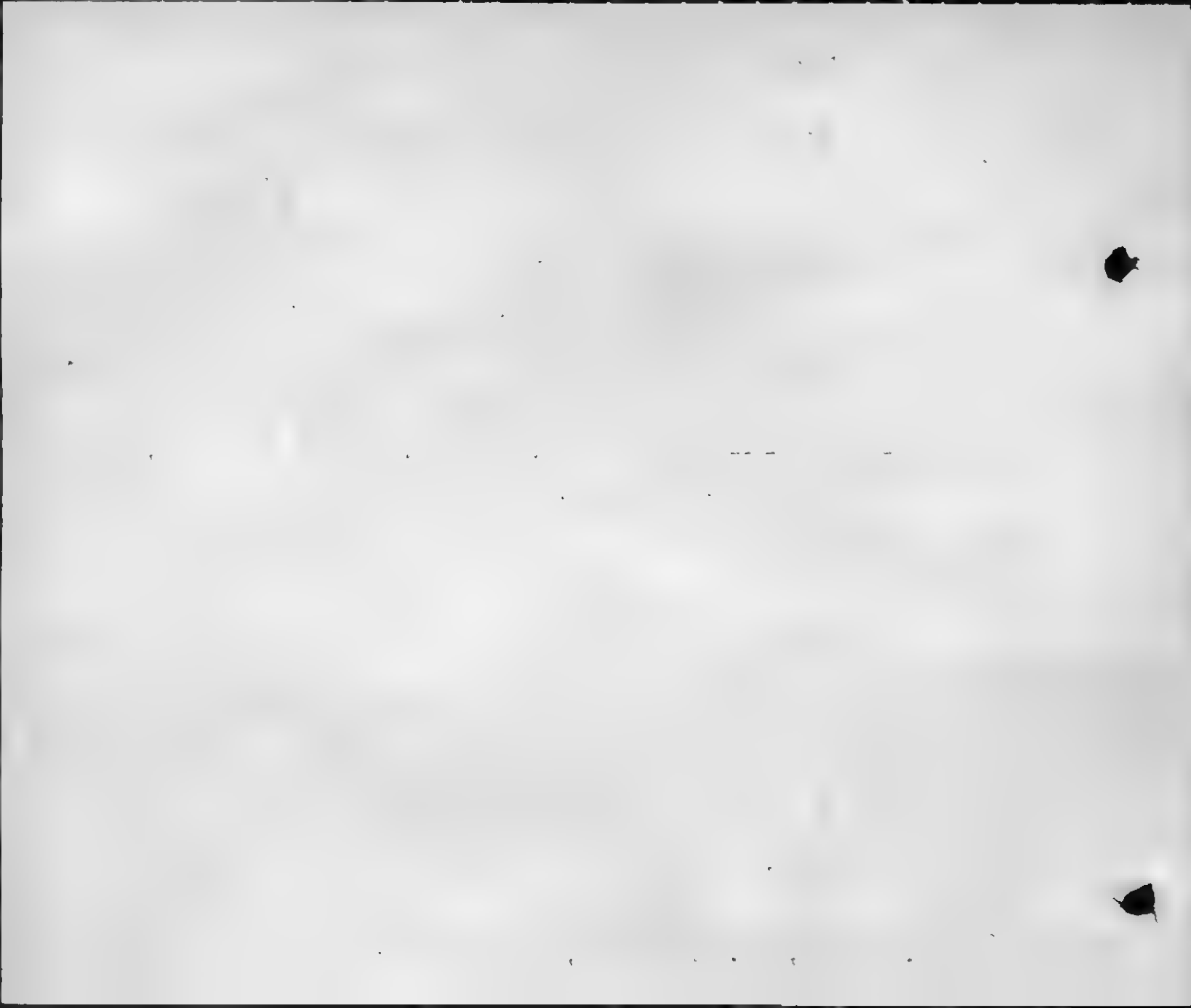
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14166

## CERTIFICATE OF DEATH

14136

|   |  |  |  |
|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br><b>a. COUNTY</b> <u>Montgomery</u> <b>MARYLAND</b><br><b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br><b>c. LENGTH OF STAY IN 1b</b> <u>9 days</u><br><b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <u>Oakhaven Convalescent Home</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, last permanent residence) <b>a. STATE</b> <u>Maryland</u> <b>b. COUNTY</b> <u>Montgomery</u><br><b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br><b>d. STREET ADDRESS</b> <u>9411 Colesville Road</u><br><b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>XXXXXXXX BERTIE P. Mason</u><br><b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>July 15, 1875</u> <b>9. AGE</b> (In years last birthday) <u>86</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>IF UNDER 24 HRS.</b> Months Days Hours Min. |  | <b>4. DATE OF DEATH</b> <u>Dec 9</u> <b>19</b> <u>61</u><br><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>West Virginia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>  |  |
| <b>13. FATHER'S NAME</b> <u>William Plumley</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Susan</u> <b>RICHMOND</b><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war and dates of service) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>NONE</u> <b>17. INFORMANT</b> <u>MR. RICHARD F. MASON SILVER SPRING, MARYLAND</u>  |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br><b>PART I. DEATH WAS CAUSED BY:</b><br><b>IMMEDIATE CAUSE (a)</b> <u>493X Peritonitis</u> <b>DUE TO</b><br><b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <b>DUE TO</b> <b>(c)</b><br><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Generalized arteriosclerosis. Anemia.</u> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 days</u> |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u><br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>   |  | <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Aug 1955</u> <b>to</b> <u>Dec 4</u> <b>1961</b> , that (I) <u>(two)</u> last saw the deceased alive on <u>Dec 8</u> <b>19</b> <u>61</u> , and that death occurred at <u>9:20</u> <b>AM</b> , from the causes and on the date stated above.   |  |
| <b>22a. SIGNATURE</b> <u>Seruth T. Kimble</u> <b>M.D.</b> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <u>9 Dec 61</u><br><b>22c. PHYSICIAN'S NAME (Type)</b> <u>SERUTH T. KIMBLE</u> <b>22d. ADDRESS</b> <u>927 Pershing Drive Silver Spring, Md.</u>                                  |  | <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>12/12/61</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>PARKLAWN CEMETERY</u> <b>23d. LOCATION (City, town or county)</b> <u>MONTGOMERY</u> <b>(State)</b> <u>MARYLAND</u>  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Pumfrey</u> <b>24a. ADDRESS</b> <u>8434 GEORGIA AVENUE SILVER SPRING, MARYLAND</u> <b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kline</u><br><b>DATE</b> <u>DEC 13 '61</u>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

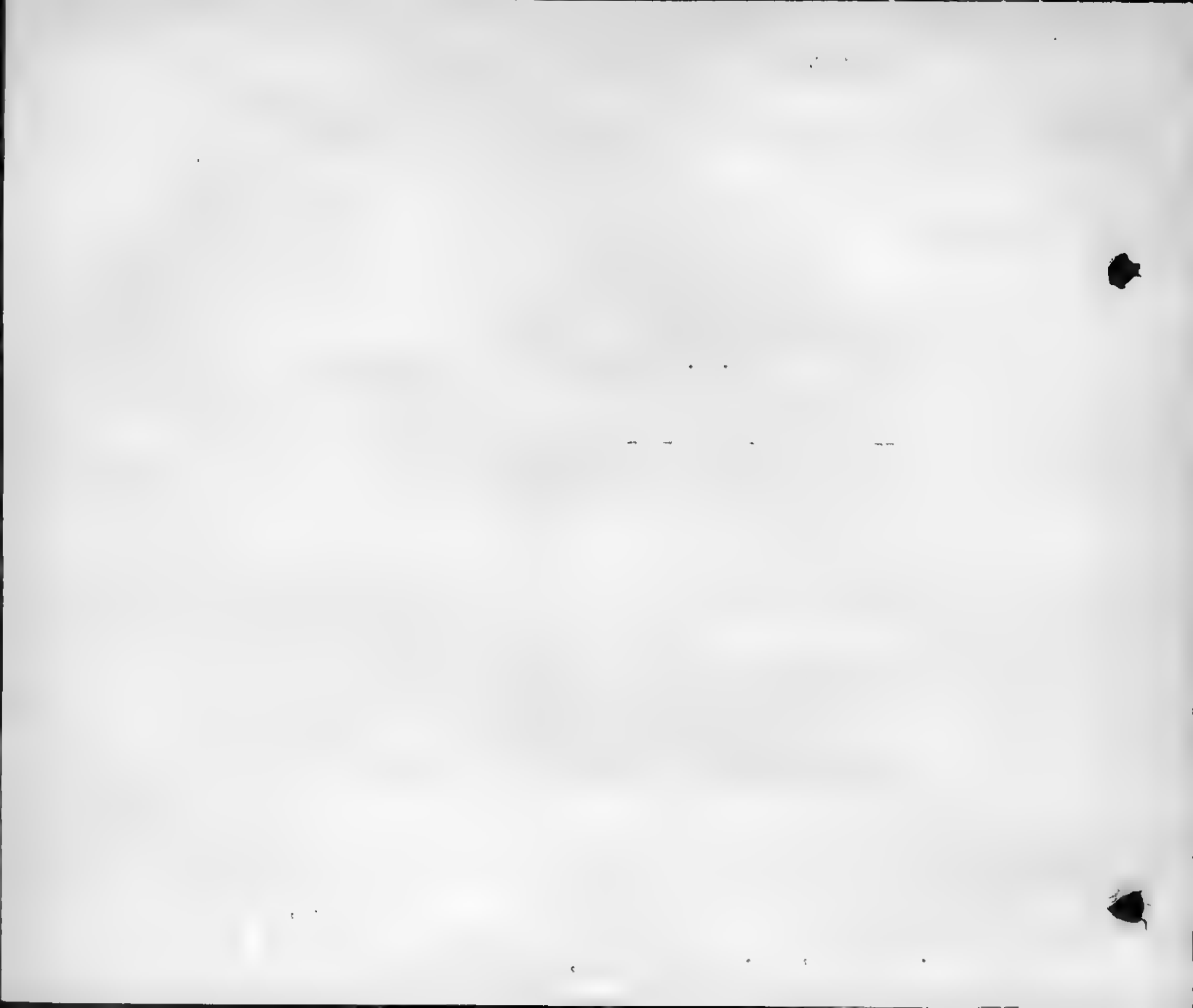
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14167

14137

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN <u>six days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>8500 New Hampshire Ave.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Mary Mathis</u>  |  | <b>4. DATE OF DEATH</b><br>Month <u>Dec</u> Day <u>18</u> Year <u>1961</u>   |  | <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>11-20-18</u> <b>9. AGE</b> (In years last birthday) <u>43</u> yrs. <b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>11. IF UNDER 24 HRS.</b> Hours <u>  </u> Min <u>  </u>                                  |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Exec. Secretary</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Mississippi</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>  |  | <b>13. FATHER'S NAME</b> <u>Wm. E. Richardson</u><br><b>14. MOTHER'S MARRIED NAME</b> <u>Emma Sue Maroney</u>  |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>426-03-7472</u> <b>17. INFORMANT</b> <u>Hospital Records</u>  |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>DUE TO <u>X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u><br>DUE TO <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> |  |  |  |  |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>  |  |  |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u><br>Hour a.m. <u>  </u> p.m. <u>  </u>   |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>  |  |  |  |
| <b>20f. (City or town)</b> <u>  </u> <b>(County)</b> <u>  </u> <b>(State)</b> <u>  </u>   |  | <b>21. I certify that (I) (the hospital) attended the deceased from <u>12 Dec</u>, 19<u>61</u>, to <u>18 Dec</u>, 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>17 Dec</u>, 19<u>61</u>, and that death occurred at <u>8:30 A.M.</u>, from the causes and on the date stated above.</b> |  |  |  |  |  |
| <b>22a. SIGNATURE</b> <u>H.B. Queen</u> <b>M.D.</b> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <u>18 Dec 1961</u>   |  | <b>22c. PHYSICIAN'S NAME (Type)</b> <u>M.B. QUEEN M.D.</u> <b>22d. ADDRESS</b> <u>7112 Willow Ave Takoma Park, MD</u>  |  |  |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>12/21/61</u>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Harris Cemetery</u>   |  | <b>23d. LOCATION (City, town or county)</b> <u>Carthage, Mississippi</u> <b>(State)</b> <u>  </u>  |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond A. Ziska</u> <b>ADDRESS</b> <u>8434 Georgia Avenue Silver Spring, Maryland</u>   |  | <b>25a. REC'D BY REGISTRAR</b> <u>DEC 20 '61</u>   |  | <b>25b. REGISTRAR'S SIGNATURE</b> <u>C. H. &amp; H. H. H.</u>  |  |  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14169

## CERTIFICATE OF DEATH

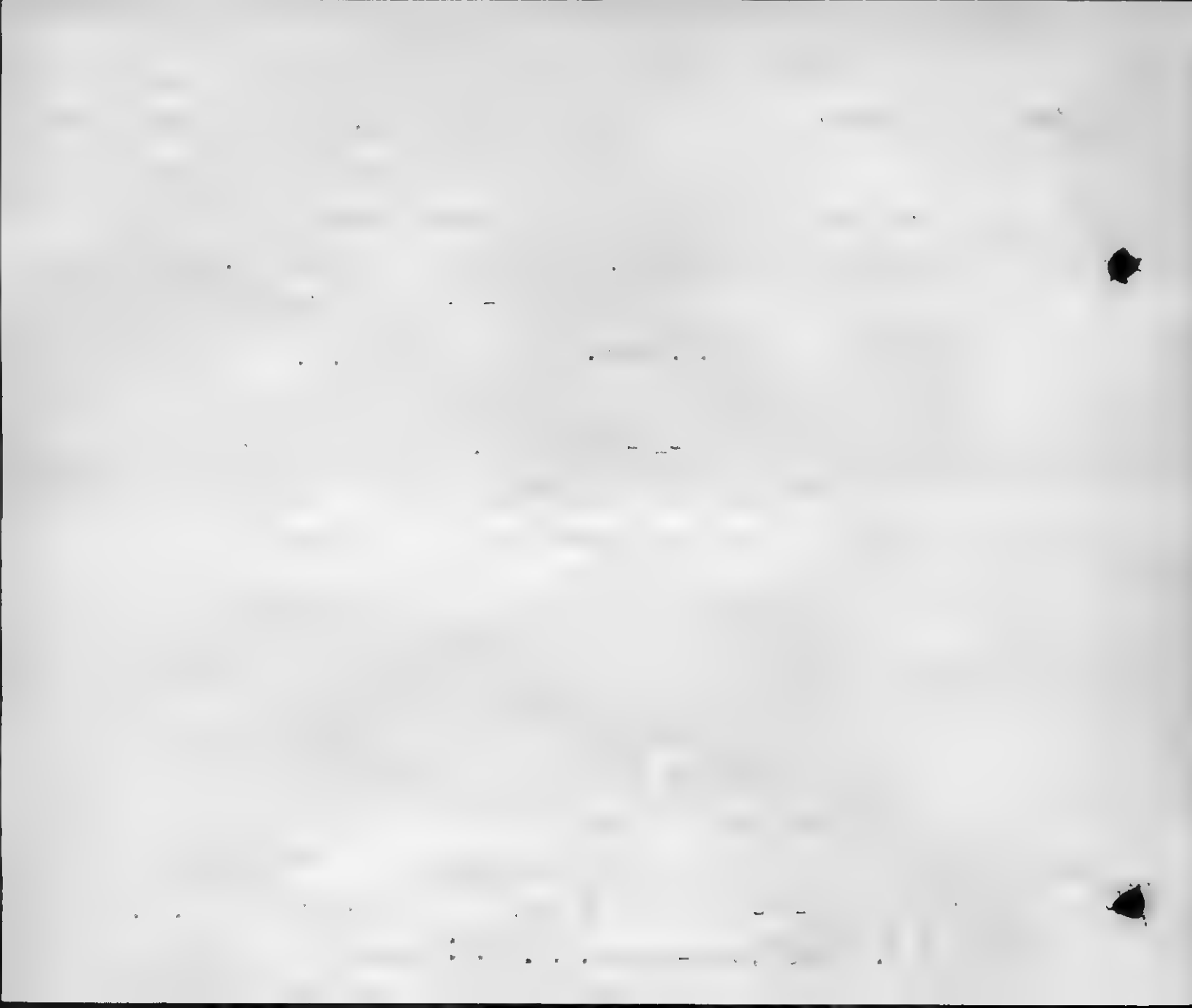
14139

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b <u>2 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>            |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>D.C.</u> <span style="float: right;">b. COUNTY <u>XXXXXXXXXXXXXX</u></span><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u><br>d. STREET ADDRESS <u>4000 Massachusetts Avenue</u> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Daniel J. McGill</u>  |  | <b>4. DATE OF DEATH</b><br><u>Dec. 28, 1961</u>   |  |
| <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b> <u>3-31-98</u> <b>9. AGE</b> (In years of birthday) <u>63</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Govt.</u>   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, D. C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>  |  |
| <b>13. FATHER'S NAME</b> <u>William Edward McGill</u>  |  | <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Linskey</u>   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> <b>16. SOCIAL SECURITY NO.</b> <u>577-10-5058</u> <b>17. INFORMANT</b> <u>Annie P. McGill, wife</u>  |  | <b>Address</b> <u>same as above</u>   |  |
| <b>18. CAUSE OF DEATH</b> (Enter on only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.0</u> <u>ACUTE MYOCARDIAL INFARCTION</u><br>(b) <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>DUE TO<br>(c) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>36 hrs.</u><br><br><u>2 yrs known</u>  |  |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>  </u>  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)   |  |
| <b>21 I certify that (I) (this hospital) attended the deceased from</b> <u>12-26</u> <u>1961</u> <b>to</b> <u>12-28</u> <u>1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>12/28</u> <u>1961</u> , <b>and that death occurred at</b> <u>8 AM</u> , <b>from the causes and on the date stated above.</b>  |  |   |  |
| <b>22a. SIGNATURE</b><br><u>Richard H. Pollen</u>  |  | <b>22b. DATE SIGNED</b><br><u>12/28/61</u>  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>RICHARD H. POLLEN, M.D.</u>  |  | <b>22d. ADDRESS</b><br><u>10511 SUMMIT AVE KENSINGTON, MD.</u>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>   |  | <b>23b. DATE THEREOF</b> <u>12-30-61</u>  |  |
| <b>23c. NAME OF CEMETERY</b> <u>Mount Olivet</u>   |  | <b>23d. LOCATION (City, town or county)</b> <u>Washington, D. C.</u>  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Francis J. Collins</u>   |  | <b>25a. REC'D BY REGISTRAR</b> <u>  </u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>  |  |
| <b>ADDRESS</b> <u>Francis J. Collins, 3821-14th St. N.W. Wash. D.C.</u>  |  | <b>DATE</b> <u>JAN 2 '62</u>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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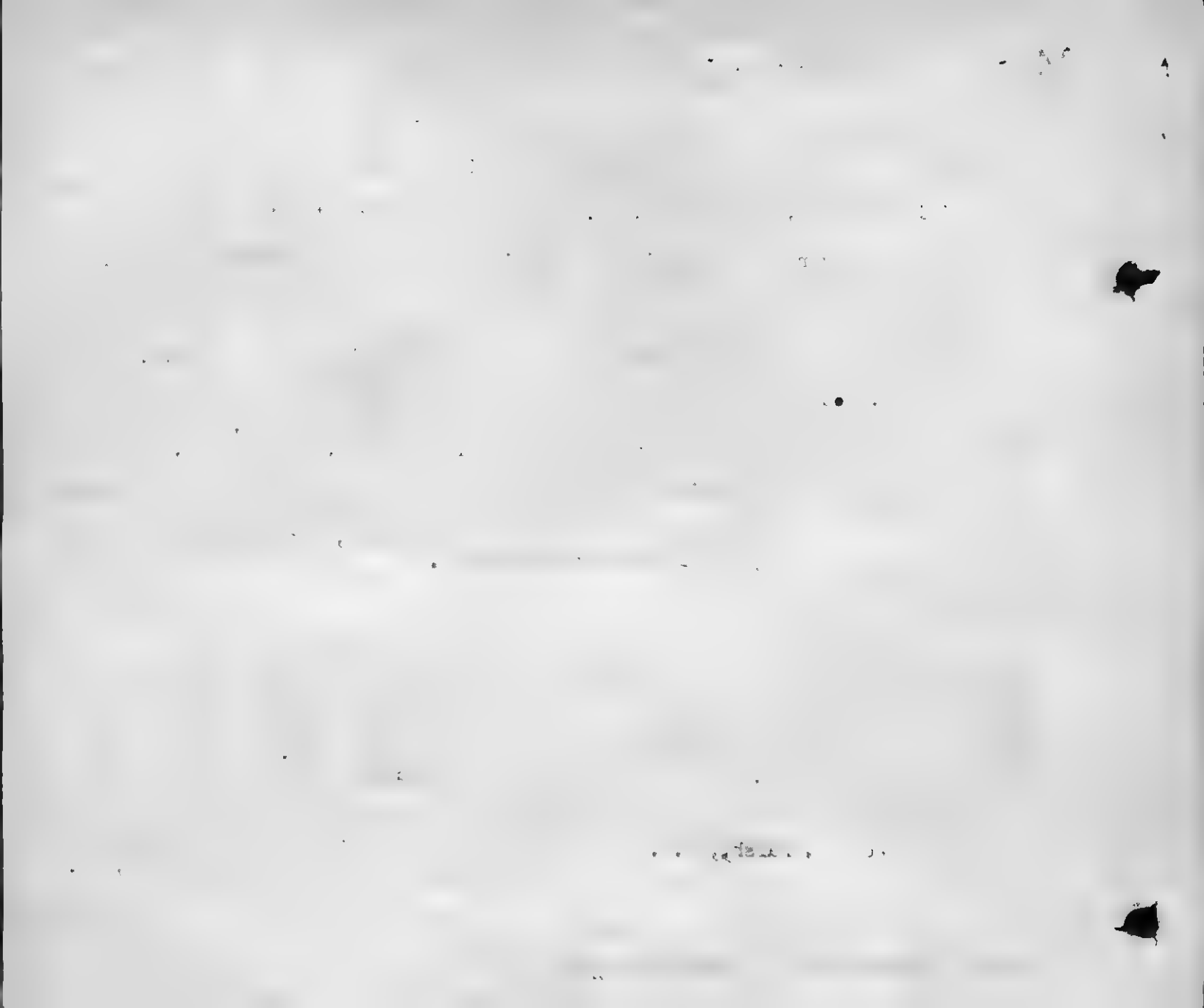
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14140

|   |  |  |  |
|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY IN 1b<br><b>74 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>The Clinical Center, Bethesda 14, Md.</b>                              |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>a. STATE<br><b>Pennsylvania</b><br>b. COUNTY<br><b>Point Marion</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>201 Boulevard Street</b><br>d. STREET ADDRESS<br><b>201 Boulevard Street</b> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><b>Everett Laing McGill</b>  |  | <b>4. DATE OF DEATH</b><br>Month<br><b>December</b><br>Day<br><b>5</b><br>Year<br><b>19 61</b>   |  |
| <b>5. SEX</b><br><b>Male</b><br><b>6. COLOR OR RACE</b><br><b>White</b>   |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/><br><b>8. DATE OF BIRTH</b><br><b>18 May 1911</b>   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Auditor</b>  |  | <b>9. AGE</b> (In years last birthday)<br><b>50 yrs.</b><br><b>11. BIRTH PLACE</b> (County & State, or foreign country)<br><b>Pennsylvania</b>   |  |
| <b>13. FATHER'S NAME</b><br><b>Joseph N. McGill</b>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Jennie Laing</b>   |  |
| <b>16. SOCIAL SECURITY NO.</b><br><b>204-10-9999</b>  |  | <b>17. INFORMANT</b><br><b>The Medical Record,</b><br><b>The Clinical Center, Bethesda 14, Maryland</b>  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br><b>PART I. DEATH WAS CAUSED BY:</b><br><b>IMMEDIATE CAUSE (a) Uremia</b><br><b>11-2 X</b><br><b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) Carcinoma of the lung with cerebral, hepatic and probable cardiac metastases.</b><br><b>11-5AM</b><br><b>CAUSE LAST. (c)</b> |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>12 days</b><br><b>1 year</b>   |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)</b><br><input type="checkbox"/>   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b>  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town)</b> (County) (State)  |  |
| <b>21. I certify that</b> <input checked="" type="checkbox"/> <b>(this hospital) attended the deceased from</b> <b>September 22, 1961, to Dec. 5, 1961,</b> <b>that (X) (we) last saw the deceased alive on</b> <b>Dec. 5, 1961,</b> <b>and that death occurred about</b> <b>11-5AM</b> <b>from the causes and on the date stated above.</b>                                |  |  |  |
| <b>22a. SIGNATURE</b><br><b>John C. Marsh</b>   |  | <b>22b. DATE SIGNED</b>  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><b>John C. Marsh, M.D.</b>   |  | <b>22d. ADDRESS</b><br><b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>BURIAL 12/7/61</b>   |  | <b>23b. DATE THEREOF</b>   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>SMITHFIELD, PENNA.</b>  |  | <b>23d. LOCATION (City, town or county)</b> (State)  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>W.W. Chambers Co., Washington, D.C.</b>   |  | <b>25a. REC'D BY REGISTRAR</b><br><b>DEC 8 '61</b>   |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Arthur S. Kane</b>  |  | <b>25c. DATE</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 1 and 2 and fill them in with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

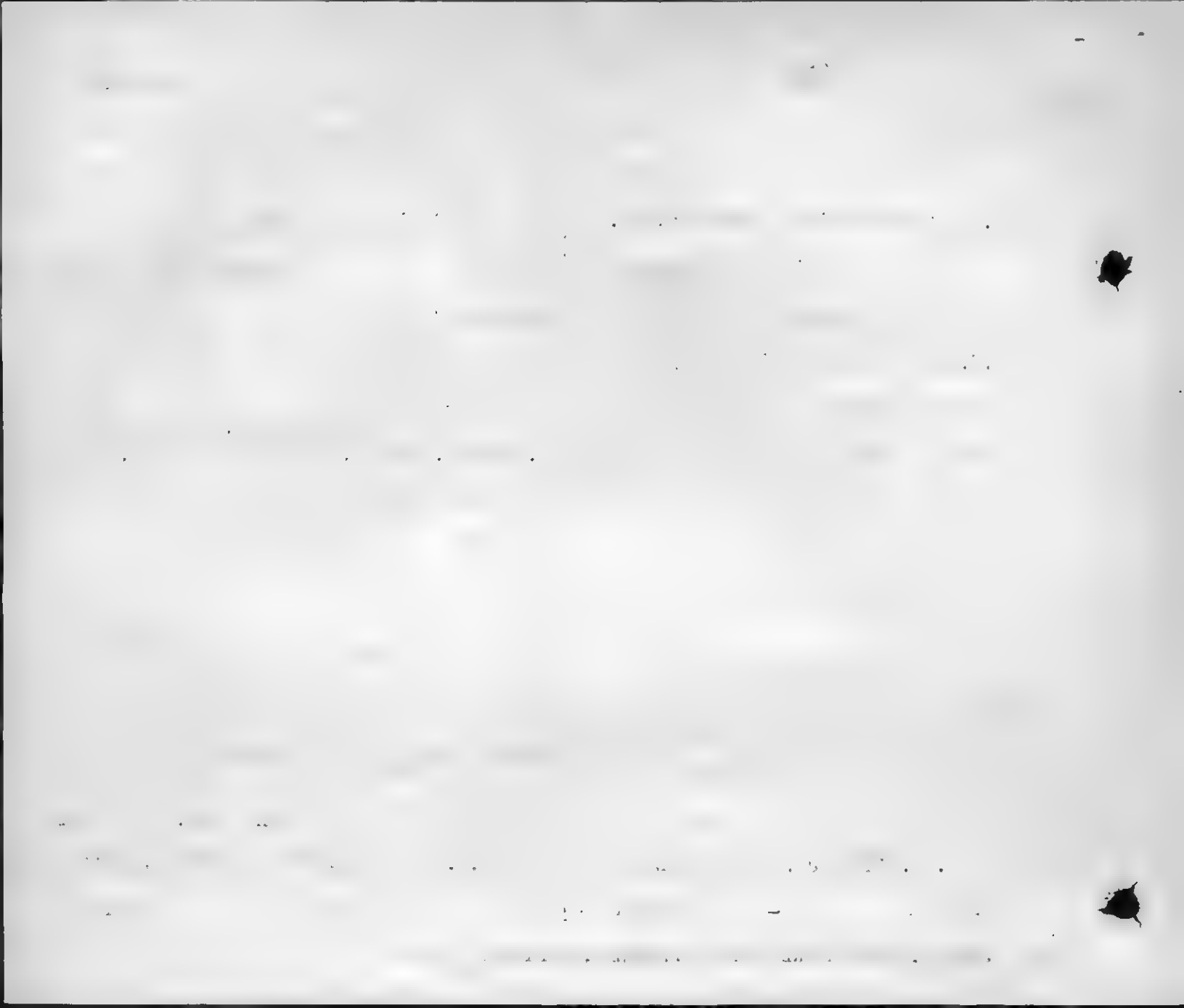
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14171

14144

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural</u><br>c. LENGTH OF STAY IN TB <u>0 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. Naval Hospital, Bethesda, Md.</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Anne Arundel</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u><br>d. STREET ADDRESS <u>715 Sprindale Avenue</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>Richard Gordon Messer</u><br>5. SEX <u>Male</u><br>6. COLOR OR RACE <u>Caucasian</u><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH <u>22 November 1903</u><br>9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u><br>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Coast Guard Retired Buyer</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u><br>11. BIRTHPLACE (County & State, or foreign country) <u>USA</u><br>12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>4. DATE OF DEATH <u>December 29 1961</u><br>13. FATHER'S NAME <u>George Messer</u><br>14. MOTHER'S MAIDEN NAME <u>Carrie Huff</u><br>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes 1920-1945</u><br>16. SOCIAL SECURITY NO. <u>  </u><br>17. INFORMANT <u>Mrs. Mary E. MESSER, 715 Sprindale Ave., Annapolis, Maryland</u><br>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Dissecting Aortic Aneurysm</u><br>DUE TO <u>  </u><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>  </u><br>DUE TO <u>  </u><br>(c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u><br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20c. TIME OF INJURY Month, Day, Year <u>  </u> <u>  </u> <u>19</u><br>Hour a.m. <u>  </u> p.m. <u>  </u><br>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u><br>20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>   |  | 21. I certify that <u>XX</u> (this hospital) attended the deceased from <u>29 December 1961</u> to <u>29 December 1961</u> that <u>XX</u> (we) last saw the deceased alive on <u>29 December 1961</u> , and that death occurred <u>805PM</u> , from the causes and on the date stated above.<br>22a. SIGNATURE <u>A. T. Thorp Jr.</u><br>22c. PHYSICIAN'S NAME (Type) <u>A. T. THORP JR. LT MC USN</u><br>22d. ADDRESS <u>U.S. Naval Hospital, Bethesda, Maryland</u><br>22b. DATE SIGNED <u>XX Dec. 30, 1961</u><br>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u><br>23b. DATE THEREOF <u>1/2/62</u><br>23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u><br>23d. LOCATION (City, town or county) <u>ANNAPOLIS</u> (State) <u>MARYLAND</u><br>24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR AND SONS</u> ADDRESS <u>ANNAPOLIS, MARYLAND</u><br>25a. REC'D BY REGISTRAR <u>  </u> DATE <u>JAN 3 '62</u><br>25b. REGISTRAR'S SIGNATURE <u>  </u>   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

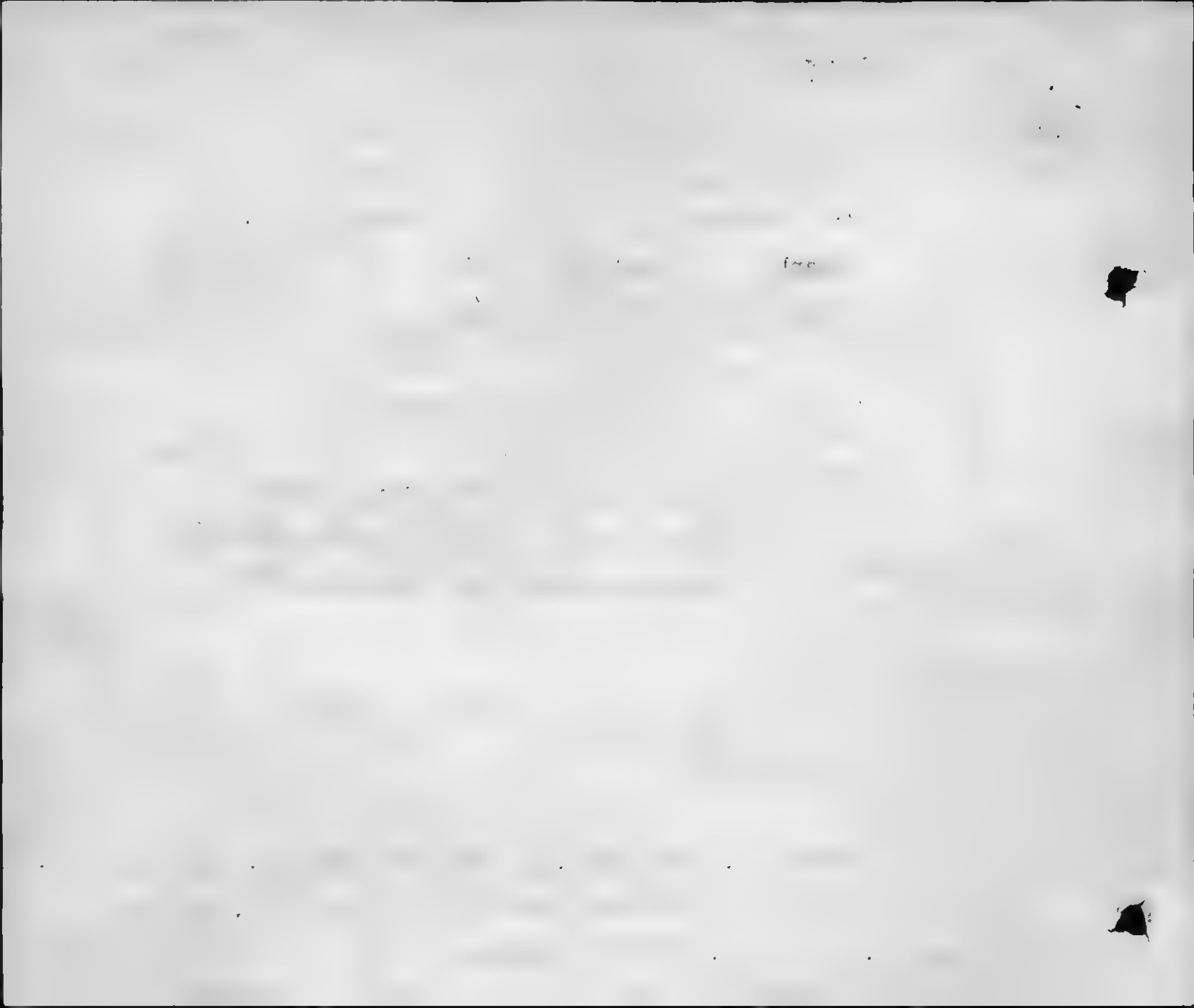
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|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b><br>c. LENGTH OF STAY IN 1b<br><b>6</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b><br>d. STREET ADDRESS <b>606 Edmonston Dr.,</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Charles Lester Messick</b><br>5. SEX <b>Male</b><br>6. COLOR OR RACE <b>White</b><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH <b>8/28/1894</b><br>9. AGE (In years, last birthday) <b>67</b> yrs.<br>IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b><br>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b><br>11. BUSINESS OR INDUSTRY <b>Retired</b><br>12. CITIZEN OF WHAT COUNTRY? <b>USA</b> |  | 4. DATE OF DEATH <b>December 4, 1961</b><br>13. FATHER'S NAME <b>Alfred Messick</b><br>14. MOTHER'S MAIDEN NAME <b>Elizabeth Biller</b><br>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b><br>16. SOCIAL SECURITY NO. <b>578-09-2357</b><br>17. INFORMANT <b>wife, Cordelia Messick-Same 2d</b><br>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Cardiac Thrombosis</b><br><b>Rupture, left ventricle</b><br><b>Myocardial infarct</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>None</b><br>(a), stating the underlying cause last. (c) <b>None</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b><br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>12</b> p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>   |  | 20f. (City or town) <b>Rockville</b> (County) <b>Montgomery</b> (State) <b>Md.</b>  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5/1/1961</b> to <b>12/4/1961</b> that (I) (we) last saw the deceased alive on <b>12/4/1961</b> and that death occurred at <b>12/4/1961</b> from the causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE <b>Stephen N. Jones</b> M.D.  |  | 22b. ADDRESS <b>809 Viers Mill Rd. Rockville, Md.</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Stephen N. Jones, M.D.</b>   |  | 22d. ADDRESS <b>809 Viers Mill Rd. Rockville, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE THEREOF <b>12/7/61</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>  |  | 23d. LOCATION (City, town or county) <b>Rockville, Maryland</b> (State) <b>Md.</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>   |  | 25a. REC'D BY REGISTRAR <b>DEC 7 '61</b> 25b. REGISTRAR'S SIGNATURE <b>W. S. Thomas</b>   |  |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician as completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A11 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

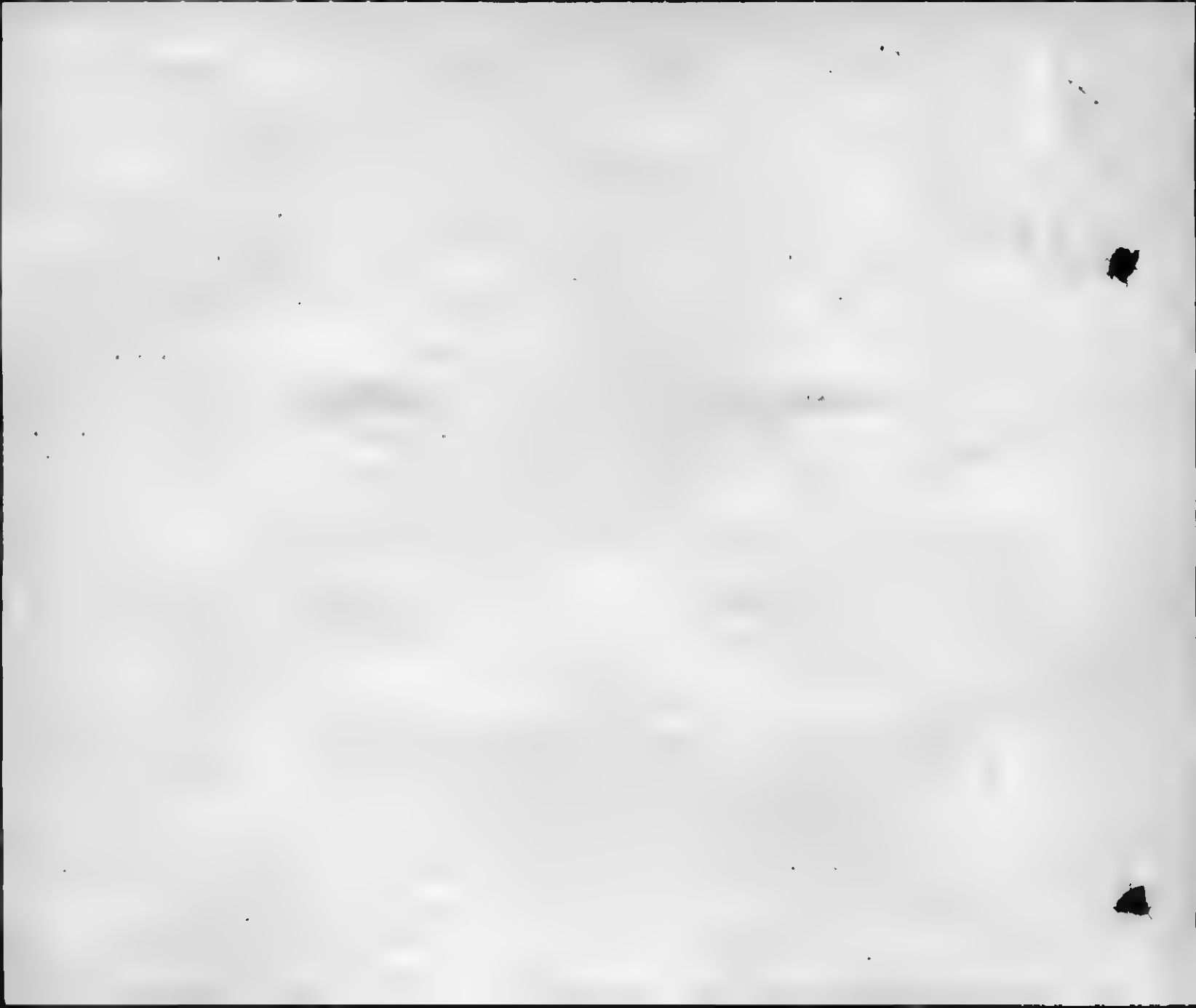
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## CERTIFICATE OF DEATH

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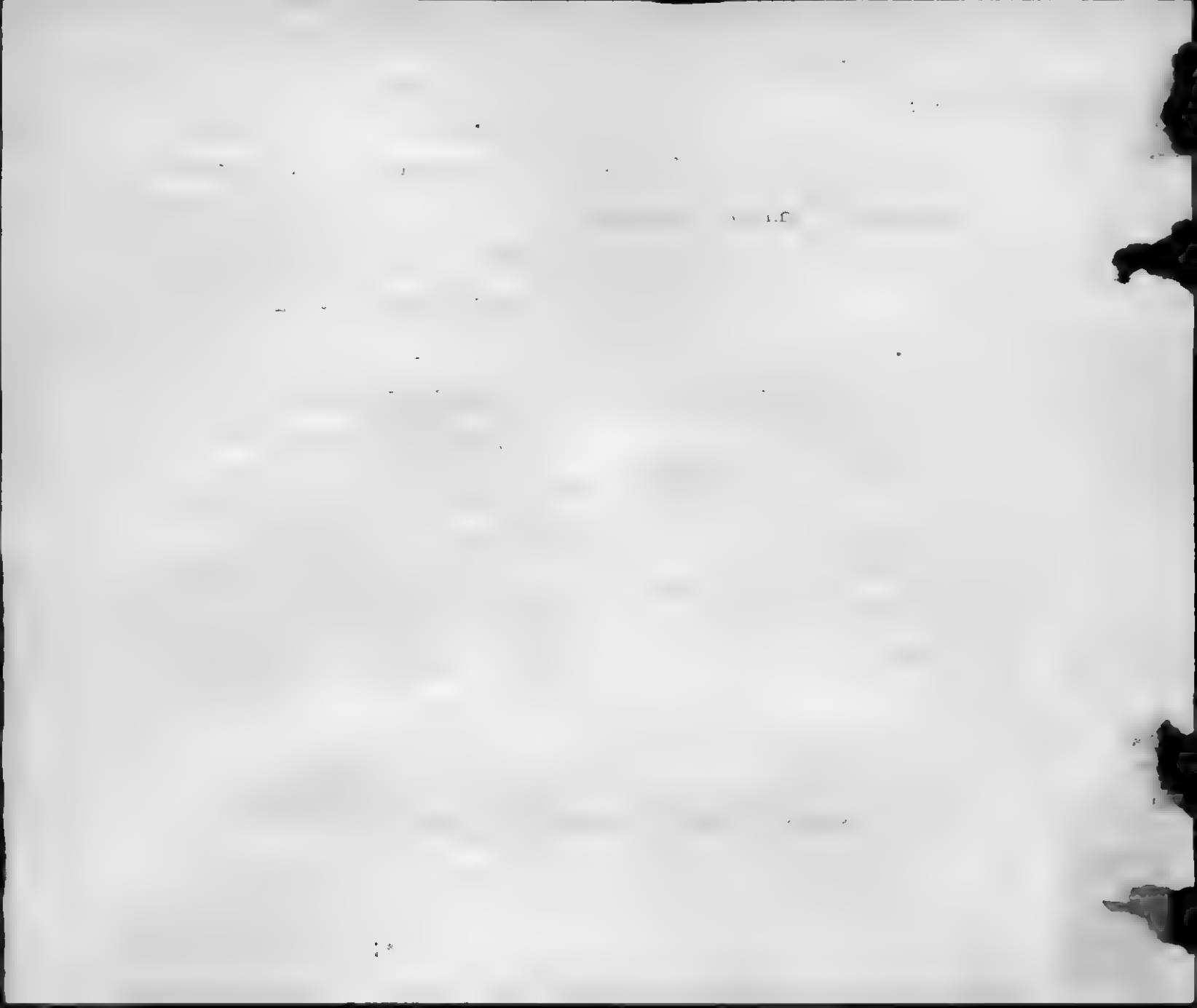
|  |                                  |   |                                     |
|--|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>e. COUNTY <b>Montgomery</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |                                     |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |                                  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Chevy Chase</b>  |                                     |
| c. LENGTH OF STAY IN b<br><b>12 days</b>   |                                  | d. STREET ADDRESS<br><b>4716 Bradley Blvd.</b>  |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Suburban Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 3. NAME OF DECEASED<br>(Type or print) <b>Sylvester Mettenburg</b>   |                                  | 4. DATE OF DEATH <b>December 2 19 61</b>  |                                     |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/16/98</b> |
| 9. AGE (in years last birthday)<br><b>63 yrs.</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>63</b> Days <b>0</b>   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Public Accountant</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Self Employed</b>   |                                     |
| 11. BIRTHPLACE (Country & State or foreign country)<br><b>Iowa</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                     |
| 13. FATHER'S NAME<br><b>Conrad Mettenburg</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Anna Hellweg</b>   |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of discharge)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |                                     |
| 17. INFORMANT<br><b>Joseph A. Cantrel</b>  |                                  | Address <b>808 17th St. NW. Washington 6, D.C.</b>  |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Atherosclerosis</b><br>(c) <b>DUE TO</b><br>(e), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>INTERVAL BETWEEN ONSET AND DEATH</b> |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> P.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.)  |                                  | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12/1/61</b> to <b>Dec 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>12/1/61</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.  |                                  |   |                                     |
| 22a. SIGNATURE<br><b>W. P. Joyce</b>   |                                  | 22b. DATE SIGNED<br><b>12/2/61</b>  |                                     |
| 22c. PHYSICIAN'S NAME (Type)<br><b>W. P. Joyce</b>   |                                  | 22d. ADDRESS<br><b>8106 Maple Ridge Road, Bethesda, Md</b>  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial-Transit-12/5/61</b>   |                                  | 23b. DATE THEREOF<br><b>12/5/61</b>   |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Johns Church Cem.</b>   |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Houghton, Iowa</b>   |                                     |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>  |                                  | 25a. RECEIVED BY REGISTRAR<br><b>DEC 6 '61</b>  |                                     |
|  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Pumphrey</b>   |                                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



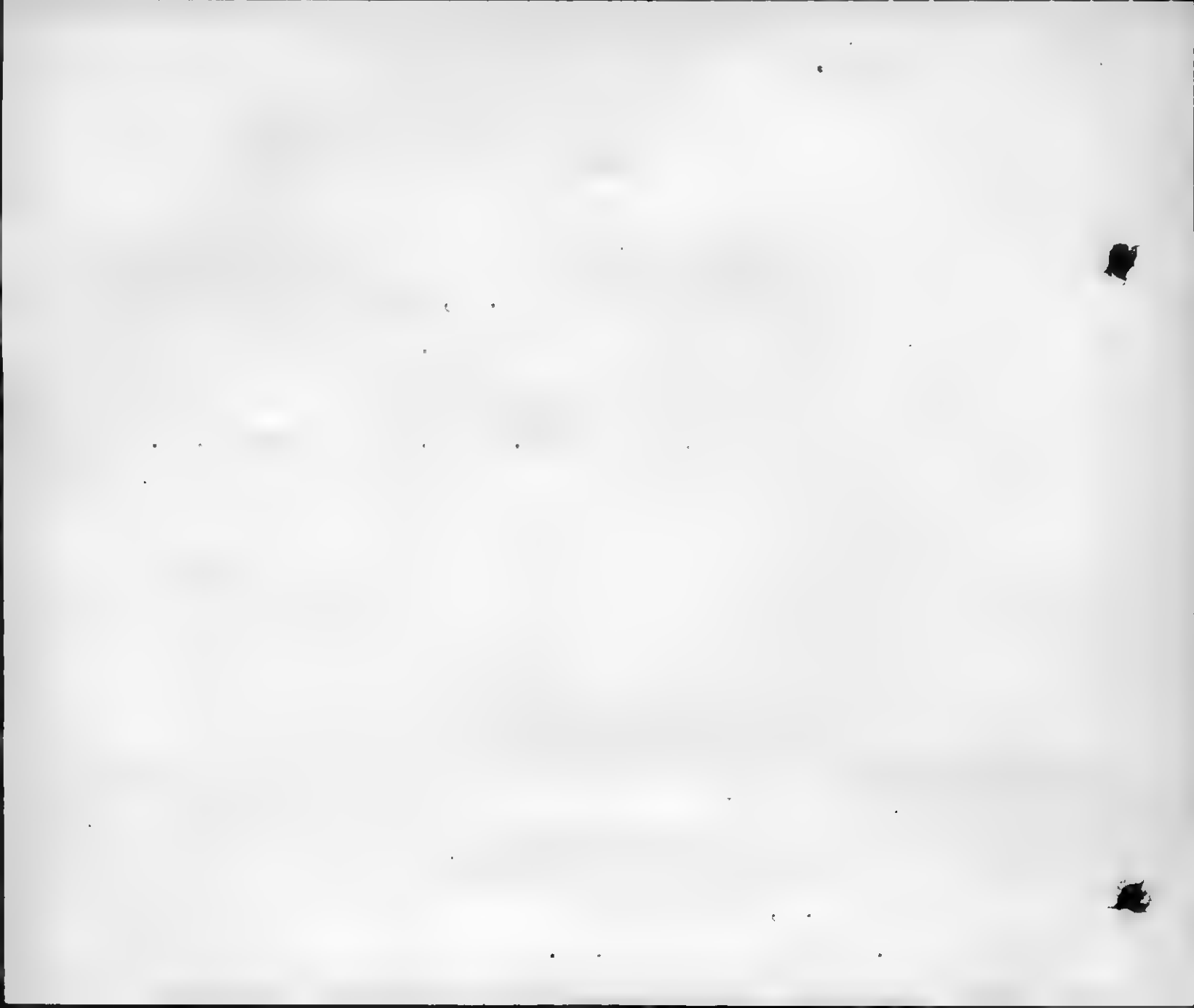






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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Buck Lodge</b><br>c. LENGTH OF STAY IN (b)<br><b>6 months</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Simpson Home</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cedar Grove Rural</b><br>d. STREET ADDRESS<br><b>1</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Jesse Alby Miles</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>December 31 1961</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>Aug. 26, 1877</b>                                      |
| 9. AGE (In years last birthday)<br><b>84 yrs</b>   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  | 11. IF UNDER 24 HRS<br>Months Days Hours Min   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>George Miles</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Ella Beal</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |   |
| 17. INFORMANT<br><b>Mrs. Ella M. Bosley</b>  |   | Address<br><b>Rockville, Md.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><b>4-4-3X Cerebral Hemorrhage</b><br>DUE TO<br>(b) <b>Cerebral Arteriosclerosis</b><br>DUE TO<br>(c) <b>Arteriosclerosis Hypertensive Cerebral Vascular Disease</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>2 year</b><br><b>16 year</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 hours</b><br><b>2 year</b><br><b>16 year</b>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>27 July 1961</b> to <b>31 Dec 1961</b> . That (I) (we) last saw the deceased alive on <b>31 Dec 1961</b> , and that death occurred at <b>8:00</b> M, from the causes and on the date stated above.  |   |  |   |
| 22a. SIGNATURE<br><b>Francis H. Barber</b>   |   | 22b. DATE SIGNED<br><b>2 Jan 62</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Good M. Smith, M.D.</b>   |   | 22d. ADDRESS<br><b>Barnesville, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>Jan. 3, 1962</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Salem</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>Cedar Grove, Maryland</b> |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Francis H. Barber</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 4 '62</b>   |   |
| ADDRESS<br><b>Laytonsville, Md.</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>William E. Hines</b>  |   |

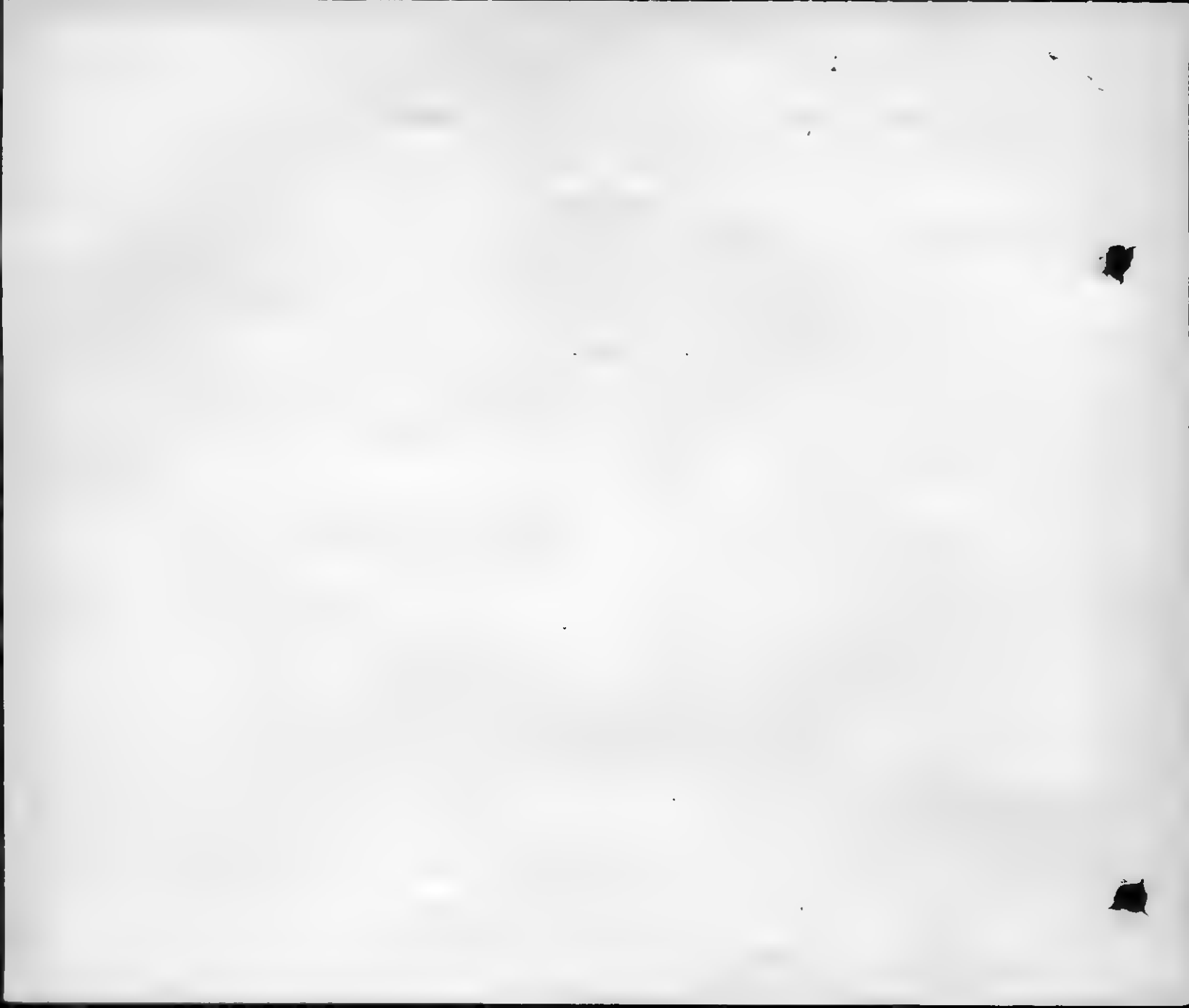


**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

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14145

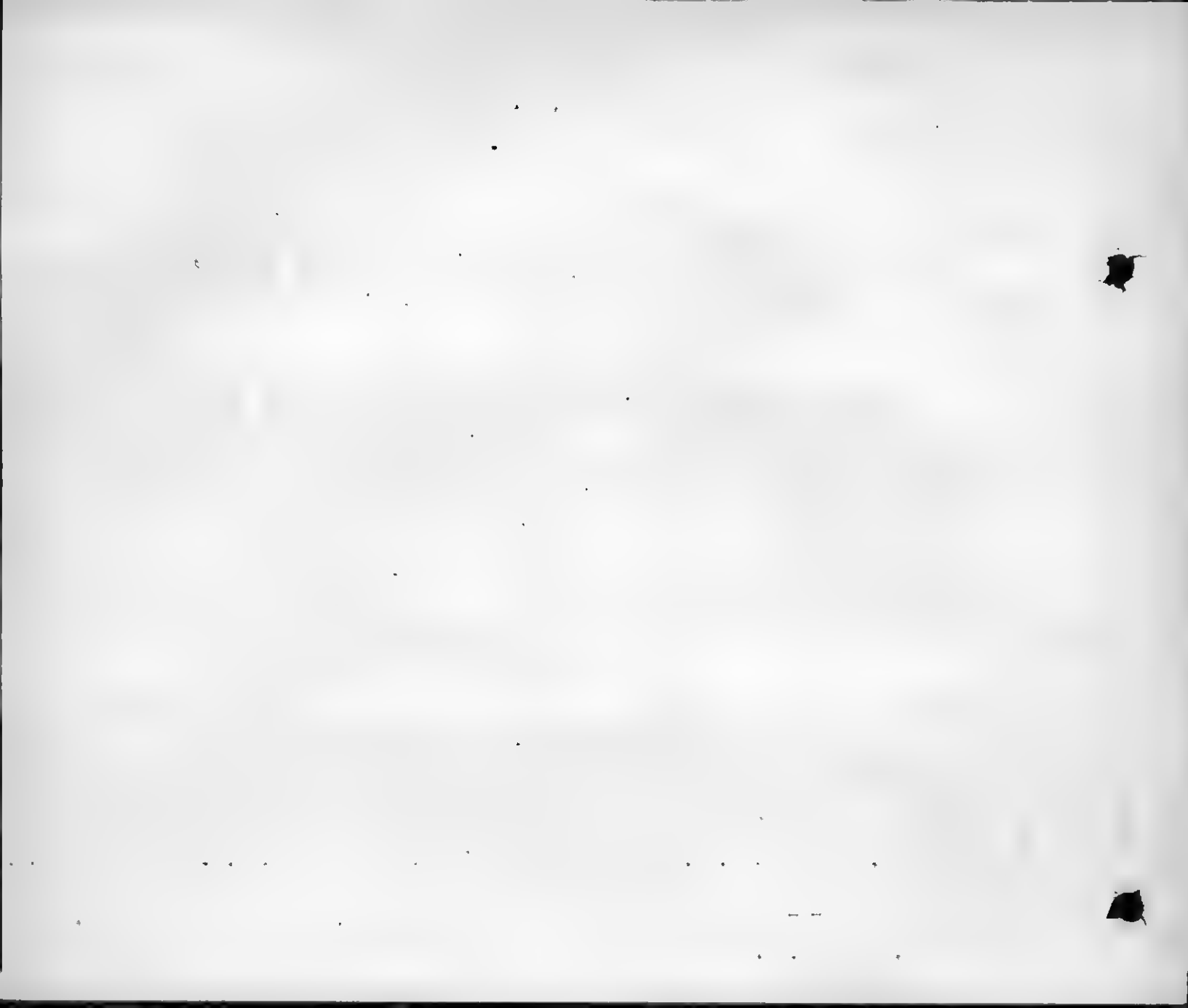
|  |                               |  |                                       |
|--|-------------------------------|--|---------------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                               | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Chevy Chase</b>   |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Congressional Manor Sanitarium</b>   |                               | d. STREET ADDRESS <b>4404 Ridge Street</b>   |                                       |
| 3. NAME OF DECEASED (Type or print) <b>Sarah Hays M. Miley</b>   |                               | 4. DATE OF DEATH <b>Dec. 15, 1961</b>  |                                       |
| 5. SEX <b>Fe.</b>  | 6. COLOR OR RACE <b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Jan. 29, 1869</b> |
| 9. AGE (In years last birthday) <b>92</b> yrs.   |                               | 10. IF UNDER 1 YEAR Months Days  | 11. IF UNDER 24 HRS. Hours Min.       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>   |                                       |
| 11. BIRTHPLACE (State or foreign country) <b>New York</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                                       |
| 13. FATHER'S NAME <b>alfred mordesai</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>sallie maynardier</b>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                               | 16. SOCIAL SECURITY NO. <b>None</b>  |                                       |
| 17. INFORMANT <b>Mrs. N. M. Asbburner-daughter-same 2d</b>   |                               | Address  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Distress</b><br><b>491X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebral Anoxia</b><br>DUE TO (c) <b>Bronchopneumonia</b> |                               | INTERVAL BETWEEN ONSET AND DEATH   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>generalized arteriosclerosis</b>  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1958</b> to <b>Dec 15, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec 13, 1961</b> , and that death occurred at <b>7:30 PM</b> from the causes and on the date stated above.   |                               |  |                                       |
| 22a. SIGNATURE <b>William Henry Killax</b>   |                               | 22b. DATE SIGNED <b>12/15/61</b>   |                                       |
| 22c. PHYSICIAN'S NAME (Type) <b>William Henry Killax</b>   |                               | 22d. ADDRESS <b>8218 Wisconsin Av Bethesda, Md</b>   |                                       |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>  |                               | 23b. DATE THEREOF <b>12/19/61</b>  |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>  |                               | 23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>  |                                       |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>   |                               | 25a. REC'D BY REGISTRAR <b>DEC 21 '61</b>  |                                       |
|  |                               | 25b. REGISTRAR'S SIGNATURE <b>Charles E. Thomas</b>  |                                       |



DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. COUNTY<br><b>Montgomery</b>                                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park,</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring,</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington Sanitarium and Hospital</b>  |                                  | d. STREET ADDRESS<br><b>11805 Idlewood Road,</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Miller</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 9, 1961</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>December 9, 1961</b>   |
| 9. AGE (In years lost birthday)<br>yrs.  |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>no</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>no</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>America</b>  |   |
| 13. FATHER'S NAME<br><b>George Preston Miller</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Frances Annette Sykes</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>no</b>   |   |
| 17. INFORMANT<br><b>father</b>   |                                  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PREMATURITY</b><br>DUE TO <b>761.55</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>VASCULAR COLLAPSE</b><br>DUE TO (c) <b>PERINATAL SEPARATION</b> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>FEW HOURS</b><br><b>FEW HOURS</b>                          |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>AFTER DELIVERY</b> , 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M., from the causes and on the date stated above.  |                                  |   |   |
| 22a. SIGNATURE<br><b>Robert L. Krichmar</b>  |                                  | 22b. DATE SIGNED<br><b>DEC 11 '61</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Robert L. Krichmar, M. D.</b>   |                                  | 22d. ADDRESS<br><b>7733 Alaska Avenue, N.W., Washington, D.C.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>  |                                  | 23b. DATE THEREOF<br><b>12-9-61</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington Sanitarium and Hospital, Takoma Park, Md.</b>  |                                  | 23d. LOCATION (City, town, or county) (State)   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Hare, M. D. Washington Sanitarium and Hospital</b>  |                                  | 25. REC'D BY REGISTRAR<br><b>DEC 11 '61</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. Hare</b>  |                                  | 25c. REGISTRAR'S SIGNATURE<br><b>Robert A. Hare</b>   |   |





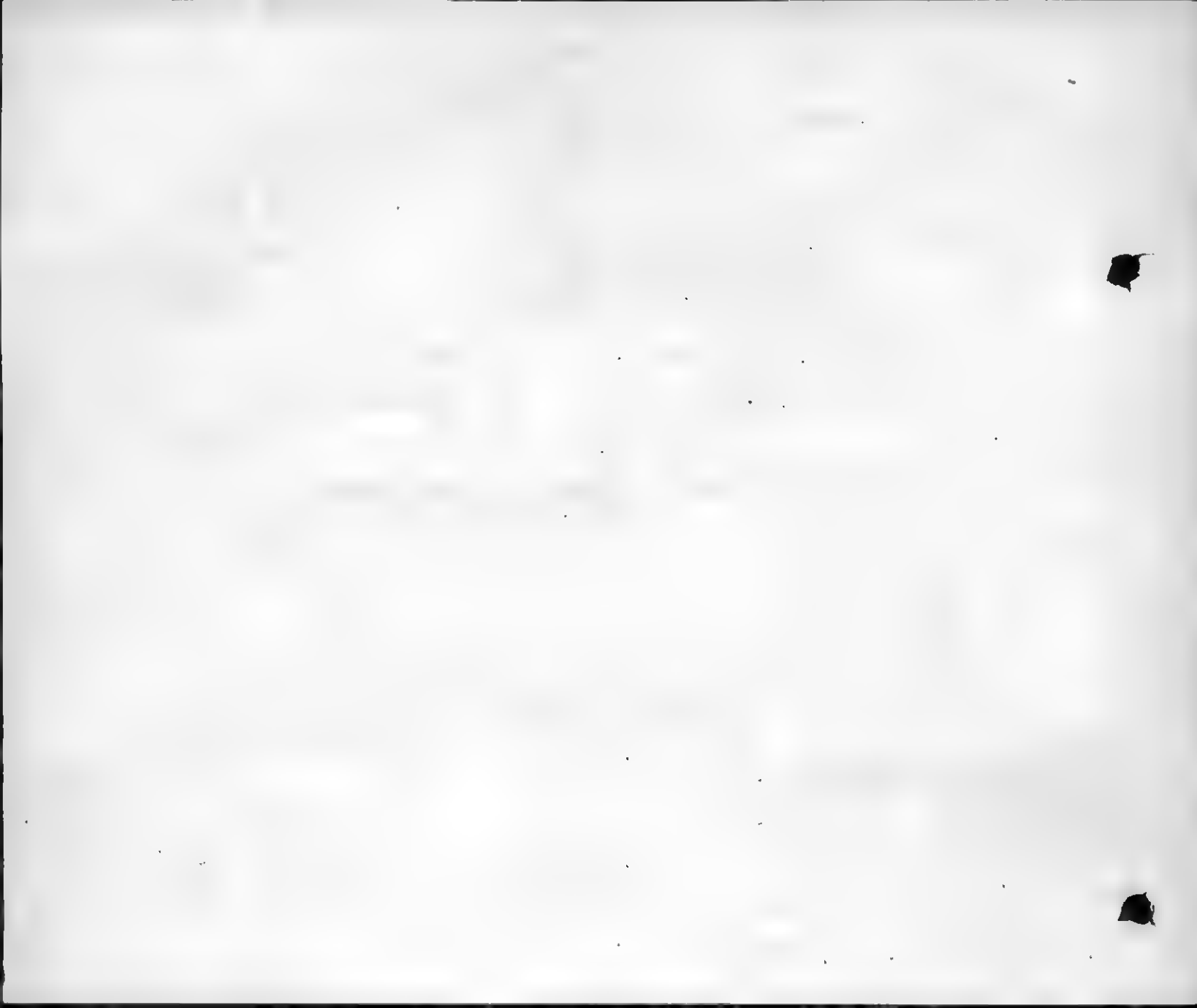
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Ref. Dist. No. 17

14177

|  |                                      |   |   |
|--|--------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b>   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Montgomery</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>43 Kensington</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION<br><b>4214 Brookfield Drive</b>  |                                      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Helen</b> Middle <b>P</b> Last <b>Miller</b>  |                                      | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>13</b> Year <b>19 61</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/15/91</b>  |
| 9. AGE (In years last birthday)<br><b>70</b>   |                                      | 10. IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>28</b> Hours <b></b> Min <b></b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Public Schools, fet Teacher</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Deleware</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>USA</b>  |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Frank M. Stoever</b>   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>(Unknown) Price</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>  |                                      | 16. SOCIAL SECURITY NO.<br><b>Yes-Unknown</b>   |   |
| 17. INFORMANT<br><b>J. W. Belt-Son in law-same 2d</b>  |                                      | Address <b></b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF RECTUM</b><br><b>14X</b> DUE TO <b>WITH METASTASES</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO <b></b><br>(c) <b></b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b><br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 MONTHS</b>                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b></b> a. m. <b></b> p. m. <b>19</b>   |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>APRIL 1957</b> to <b>DECEMBER 13 1961</b> , that I last saw the deceased alive on <b>DECEMBER 13 1961</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>7733 ALASKA AVENUE N.W. DEC. 13 1961</b><br>DATE SIGNED <b></b>   |                                      |   |   |
| ACTUAL SIGNATURE <b>Robert L. Krichmar</b>   |                                      | M.D. <b>7733 ALASKA AVENUE N.W. DEC. 13 1961</b>  |   |
| PHYSICIAN'S NAME (Type) <b>ROBERT L. KRICHMAR</b>  |                                      | <b>WASHINGTON 12 D.C.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>12/16/61</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Washington, D. C.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>  |                                      | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 21 '61</b>   |   |
|  |                                      | 24b. REGISTRAR'S SIGNATURE<br><b>J. A. Hanna</b>  |   |



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the Deputy Medical Examiner should execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

FOR STATE  
HEALTH DEPT.

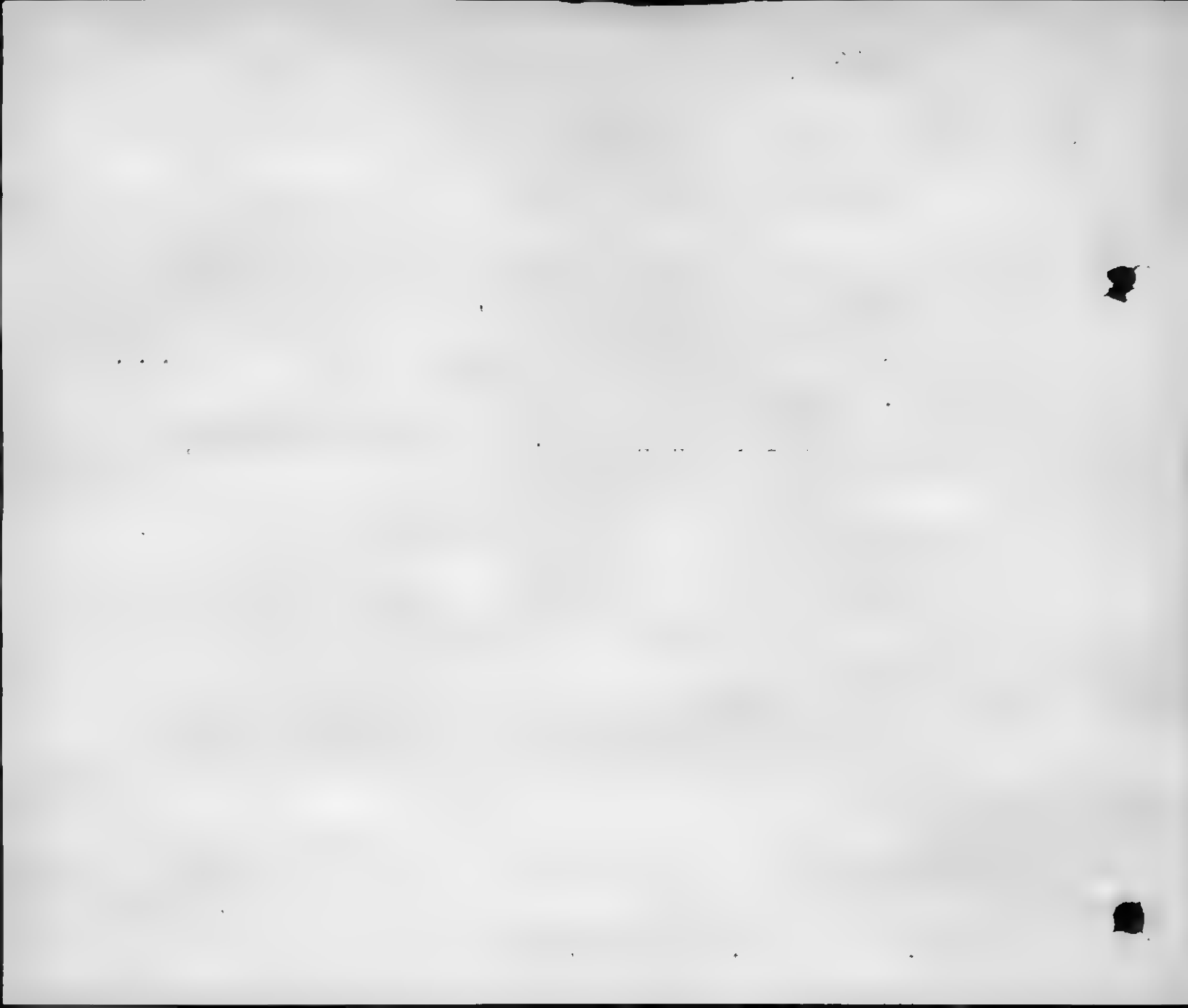
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14178

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14178 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |  |  |   |  |   |  |  |  |  |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|--|--|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery  |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Spencerville |  | c. LENGTH OF STAY IN TB<br>five years   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE<br>Maryland |  | b. COUNTY<br>Montgomery  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Spencerville |  | d. STREET ADDRESS<br>Thompson Road   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>JAMES LUTHER MINNICK  |  | First  |  | Middle  |  | Last  |  | 4. DATE OF DEATH<br>December 17 19 61                                  |  | Month  |  | Day  |  | Year  |  |   |  |
| 5. SEX<br>Male  |  | 6. COLOR OR RACE<br>White  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>May 10, 1880  |  | 9. AGE (In years last birthday)<br>81 yrs.                             |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Farmer - selfemployed  |  | 11. BIRTHPLACE (State or foreign country)<br>Virginia   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 13. FATHER'S NAME<br>James D. Minnick   |  | 14. MOTHER'S MAIDEN NAME<br>XXXXX Cheuning   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) No   |  | 16. SOCIAL SECURITY NO.<br>218-38-7758  |  | 17. INFORMANT<br>Mr. Walter Minnick                                    |  | Address<br>Thompson Road<br>Spencerville, Maryland   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) }<br>(a), stating the underlying cause last. (c) }<br>Coronary occlusion<br>Interval between onset and death<br>Found dead in bed   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)     |  | 20c. TIME OF INJURY<br>Month. Day. Year<br>Hour a.m. p.m.<br>19   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town)<br>(County)<br>(State)   |  | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | DATE SIGNED<br>12-18-61                 |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>Frank J. Broschert  |  | 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 22b. DATE THEREOF<br>12/20/61   |  | 22c. NAME OF CEMETERY OR CREMATORY<br>New Hope Baptist Cemetery   |  | 22d. LOCATION (City, town, or country)<br>Orange County, Virginia      |  | 23. FUNERAL DIRECTOR<br>A. Ziska<br>Wardner E. Pumphrey, Inc.                                    |  | 24a. REC'D BY REGISTRAR<br>DEC 20 1961   |  | 24b. REGISTRAR'S SIGNATURE<br>L. L. Thomas  |  | Address (Street, city, town, or county) |  |




## CERTIFICATE OF DEATH

14179

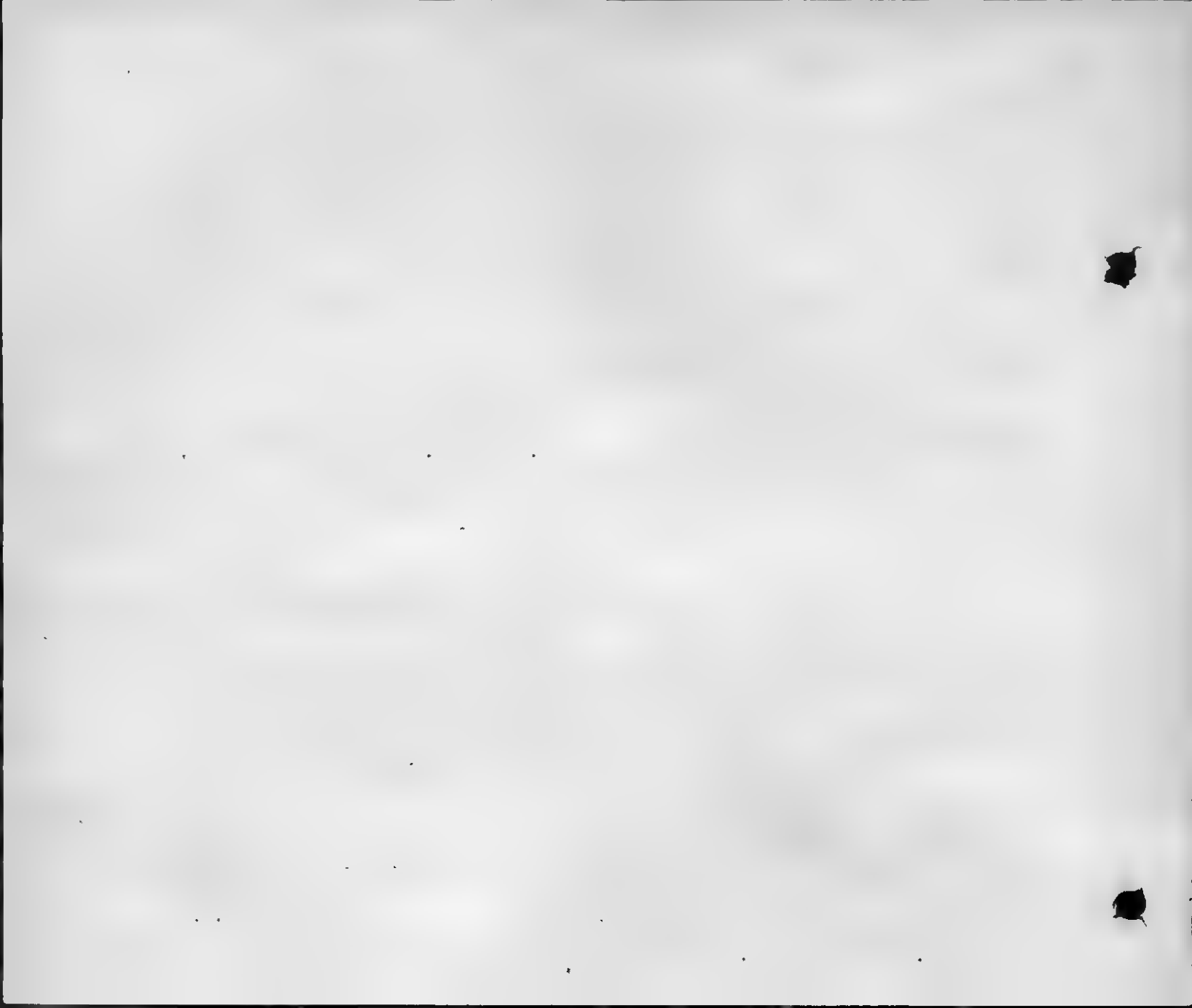
14149

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and  completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MONTGOMERY</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Wheaton</u><br>c. LENGTH OF STAY IN IB<br><u>21 months</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Wheaton Nursing Home</u>                    |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>e. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u><br>d. STREET ADDRESS<br><u>8712 COLESVILLE RD.</u> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>EVELYN HOLLAND MONROE</u><br>First Middle Last  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br><b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>8</u> Year <u>1961</u>   |  |
| <b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>3-23-1870</u>   |  | <b>9. AGE</b> (In years as of birthday) <u>91</u> <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Homemaker</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>own home</u>  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Washington, D.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u>   |  |
| <b>13. FATHER'S NAME</b><br><u>JAMES HOLLAND</u>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Margaret Flenner</u>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give wear or dates of service)<br><u>No</u>   |  | <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b><br><u>Mrs. Frank J. Rapee</u>   |  |
| <b>18. CAUSE OF DEATH</b> (Enter on only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><u>332X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)<br><u>Cerebral Thrombosis -</u><br><u>Cerebral Arteriosclerosis</u> } (c) |  | Address <u>8712 Colesville Road</u><br><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part I. of item 18.)   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec 3</u> , 19 <u>61</u> , to <u>Dec 8</u> , 19 <u>61</u> , that (I) <u>  </u> last saw the deceased alive on <u>Dec 7</u> , 19 <u>61</u> , and that death occurred at <u>2:30</u> P.M., from the causes and on the date stated above.                             |  |   |  |
| <b>22a. SIGNATURE</b><br><u>Neil P. Campbell</u>   |  | <b>22b. DATE SIGNED</b><br><u>12/8/61</u>   |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Neil P. Campbell</u>   |  | <b>22d. ADDRESS</b><br><u>Kenesaw Apt</u>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>BURIAL</u>  |  | <b>23b. DATE THEREOF</b><br><u>12/11/61</u>   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>GLENWOOD CEMETERY</u>  |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>WASHINGTON D.C.</u>   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Warner E. Pumphrey, Inc.</u>   |  | <b>25a. REC'D BY REGISTRAR</b> <u>DEC 13 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b><br><u>  </u>   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 14180 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14150

101  
FOR STATE  
HEALTH DEPT.

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

REXEMER Chevy Chase

c. LENGTH OF STAY IN TB

1 yr

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

4411 Walsh Street

3. NAME OF DECEASED (Type or print)

Matthias Paul Monson

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED

☒ NEVER MARRIED

☐ DIVORCED

8. DATE OF BIRTH

3-12-28

9. AGE (In years last birthday)

33

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Physicist

10b. KIND OF BUSINESS OR INDUSTRY

F.A.A.

11. BIRTHPLACE (State or foreign country)

D.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Matthias Monson

14. MOTHER'S MAIDEN NAME

Mary Peterson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

Yes WW 2

16. SOCIAL SECURITY NO.

Yes Unknown

17. INFORMANT

Patricia Monson (wife) Item 2

18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

974X DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

Asphyxia hanging

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN ONSET AND DEATH

Found hanging in garage at home

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

SIGNATURE Frank J. Bluscham

CHIEF MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S NAME (Type) FRANK J. Bluscham

DEPUTY MEDICAL EXAMINER

12-31-61

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

1/3/62

22c. NAME OF CEMETERY OR CREMATORY

Arlington Cemetery

22d. LOCATION (City, town, or county)

Arlington, Virginia

23. FUNERAL DIRECTOR

Robert A. Pumphrey, Bethesda, Maryland

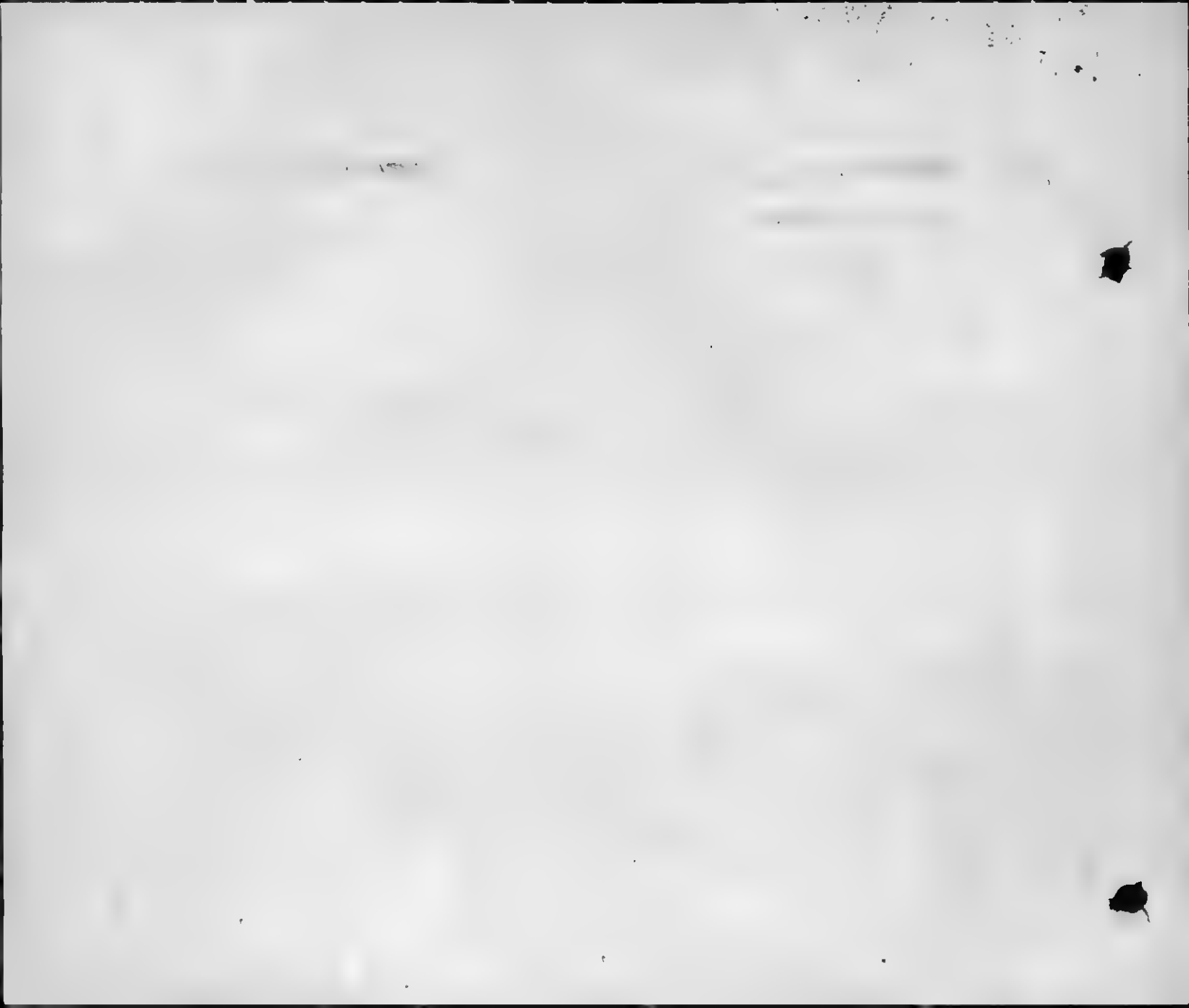
24a. REC'D BY REGISTRAR

JAN 3 '62

24b. REGISTRAR'S SIGNATURE

John S. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Every delay is necessary. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14181

14151

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH  
COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY (In days)

DOA

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sanitarium & Hosp.

2. USUAL RESIDENCE (Where deceased lived, if instilled on: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

6913 Piney Br. Rd.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED  
(Type or print)

Isaac Roland Moore

4. DATE OF DEATH

Month

Day

Year

12

4

1961

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED ☒

8. DATE OF BIRTH

8-31-98

9. AGE (In years last birthday)

69 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

Isaac Moore

14. MOTHER'S MARY NAME

SUSAN Miles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

Yes - WW I - Army

16. SOCIAL SECURITY NO.

578 14 5616

17. INFORMANT

James E. Moore - 138 E St S E D.C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.

(b)

DUE TO

(c)

Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

History of previous coronary disease

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY

Month Day Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour a.m.

p.m.

19

While at work

Not While at work

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschart

M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S NAME (Type)

FRANK J. Broschart

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

12-4-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Dec. 7, 1961

22c. NAME OF CEMETERY OR CREMATORY

Burtonsville Union Cemetery

22d. LOCATION (City, town, or county)

Montgomery Co., Maryland

(State)

23. FUNERAL DIRECTOR

Raymond A. Ziska

ADDRESS

Silver Spring, Md.

24a. REC'D BY REGISTRAR

DEC 6 '61

24b. REGISTRAR'S SIGNATURE

12-4-61

WALTER E. PUMPUREY, INC. 8434 Georgia Ave.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the funeral director, Page 1, 2, and 3 of the funeral director's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14182

14152

### 1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BETHESDA

c. LENGTH OF STAY IN Ill

9 DAYS

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

6111 DUNLEER COURT

### 2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

a. STATE

OHIO

b. COUNTY

CUYAHOGA

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

PEREA

72 X 3

d. STREET ADDRESS

201 S. ROCKY RIVER DRIVE

e. IS RESIDENCE

ON A FARM?

YES ☐ NO ☒

### 3. NAME OF DECEASED (Type or print)

LUNA

First

STEWART

Middle

MORGAN

### 4. DATE OF DEATH

Month

DECEMBER

Day

Year

1961

### 5. SEX

FEMALE

### 6. COLOR OR RACE

WHITE

### 7. MARRIED

☐ NEVER MARRIED ☐

☒ WIDOWED

☐ DIVORCED ☐

### 8. DATE OF BIRTH

1913

### 9. AGE (In years last birthday)

48

### 10. IF UNDER 1 YEAR

Months Days

### 11. IF UNDER 24 HRS.

Hours M.n.

### 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

OFFICE WORKER

### 10b. KIND OF BUSINESS OR INDUSTRY

REAL ESTATE

### 11. BIRTHPLACE (County & State, or foreign country)

PEREA, OHIO

### 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

### 13. FATHER'S NAME

DAVID HAMMOND

STEWART

### 14. MOTHER'S MAIDEN NAME

SARAH FRANCES GIESSE

### 15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give war and dates of service)

### 16. SOCIAL SECURITY NO.

27220-32-2

### 17. INFORMANT

MRS. HOMER THRALL

### Address

6111 DUNLEER CT. BETHESDA, MD

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

#### PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

4-20-61 DUE TO CONGESTIVE HEART FAILURE MYOCARDIAL INFARCTION

ASPHYXIA; PULMONARY EDEMA

### INTERVAL BETWEEN ONSET AND DEATH

5 WEEKS 15 WEEKS

#### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL D SEASE CONDIT ON GIVEN IN PART I(a)

GENERALIZED ARTERIOSCLEROSIS

### 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

### 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

### 20c. TIME OF INJURY

Month, Day, Year

Hour a.m. p.m.

### 20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

### 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

### 20f. (City or town)

### (County)

### (State)

21. I certify that (I) (this hospital) attended the deceased from NOV. 27, 1961, to DEC. 20, 1961, that (I) (we) last saw the deceased alive on DEC. 19, 1961, and that death occurred at 7 P.M. from the causes and on the date stated above.

### 22a. SIGNATURE

Joseph D. Cunniff

M.D.

### ATTENDING PHYS

### MED. DIRECTOR

### STAFF PHYS.

DEC 20 1961

### 22c. PHYSICIAN'S NAME (Type)

JOSEPH D. CUNNIFF

### 22d. ADDRESS

19420 OLD GEORGETOWN RD BETHESDA

### 23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial-Transit 12/6/61

### 23b. DATE THEREOF

### 23c. NAME OF CEMETERY OR CREMATORY

Lake Park Cemetery

### 23d. LOCATION (City, town or county)

South Youngstown, Ohio

### 24. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey, Bethesda, Maryland

### ADDRESS

### 25a. REC'D BY REGISTRAR

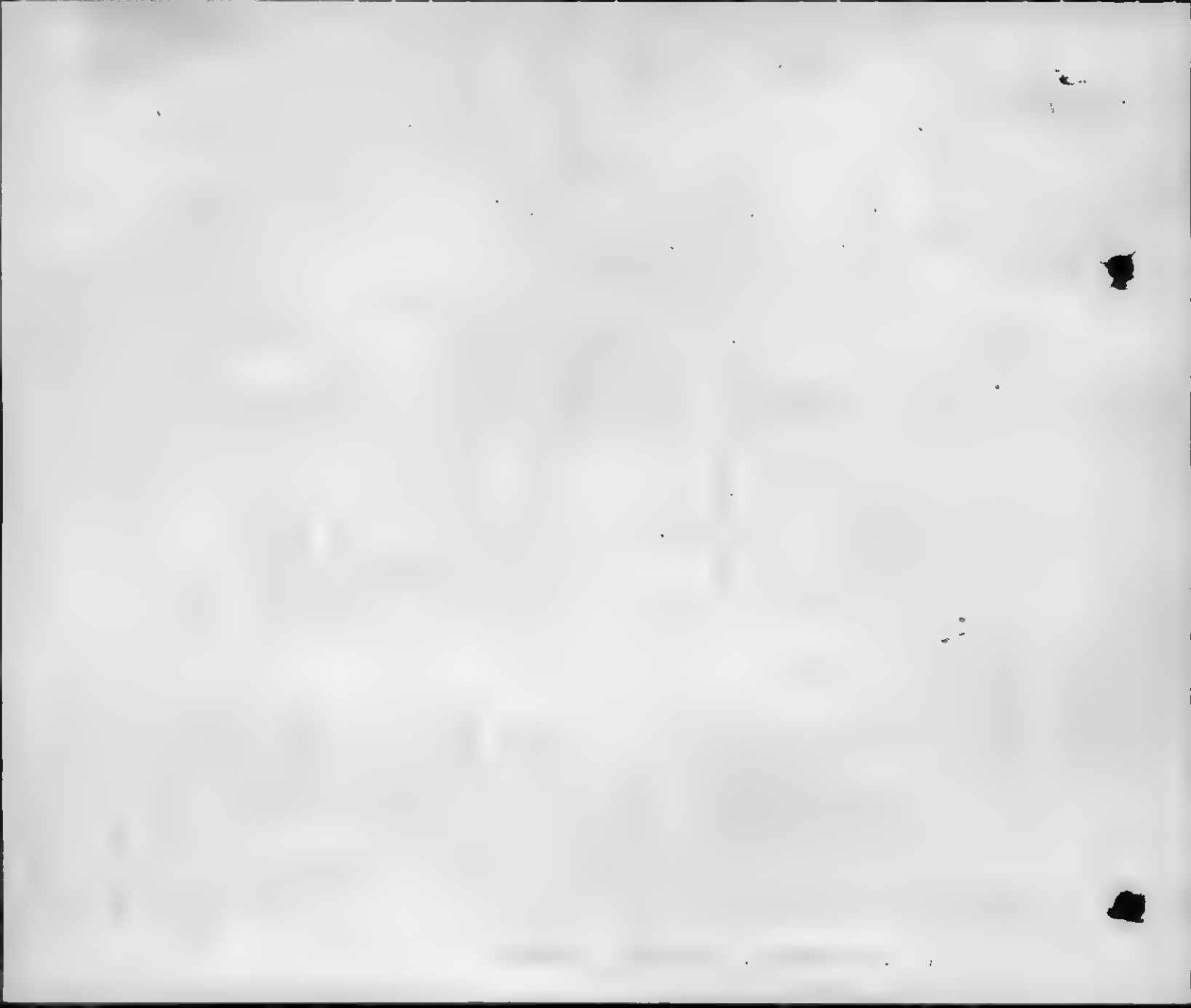
DEC 7 '61

### 25b. REGISTRAR'S SIGNATURE

Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



14183

## CERTIFICATE OF DEATH

Reg. Dist. No. 14153

|   |                               |   |  |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BOYDS</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>   |                               | e. STREET ADDRESS <u>Box 268 Route #1</u>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>MORTON</u>  |                               | 4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>6</u> Year <u>1961</u>  |  |
| 5. SEX <u>MALE</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>DEC. 6, 1961</u>               |
| 9. AGE (In years last birthday) yrs. <u>7</u> Months <u>5</u> Days <u>5</u> Mins. <u>7</u>  |                               | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                               | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>BOBBY GENE MORTON</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>AGNES LILLIAN BREEDEN</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |                               | 16. SOCIAL SECURITY NO. <u>NO</u>   |  |
| 17. INFORMANT <u>MOTHER</u>   |                               | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ATELECTASIS, INTRACRANIAL HEMORRHAGE</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY</u><br>DUE TO<br>(c) <u>7 hr 57 min</u> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>7 hr 57 min</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <u>19</u> p. m.  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>DEC. 6, 1961</u> , to <u>DEC. 6, 1961</u> , that I last saw the deceased alive on <u>DEC. 6, 1961</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.  |                               |   |  |
| ACTUAL SIGNATURE <u>Theodore H. Anders</u> M.D.   |                               | ADDRESS (Street, city or town, state) <u>4700 Bradley Blvd Chevy Chase, Md</u> DATE SIGNED <u>12-6-61</u>                                     |  |
| PHYSICIAN'S NAME (Type) <u>THEODORE H. ANDERS</u>   |                               |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF             | 22c. NAME OF CEMETERY OR CREMATORY  | 22d. LOCATION (City, town, or county) (State)      |
| <u>CREMATION</u>  | <u>12-7-61</u>                | <u>SUBURBAN HOSPITAL</u>  | <u>BETHESDA, MARYLAND</u>                          |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Amelia C. Carter, Admin. Suburban Hosp Bethesda, Md.</u>  |                               | 24a. REC'D BY REGISTRAR DATE <u>DEC 20 '61</u>  | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

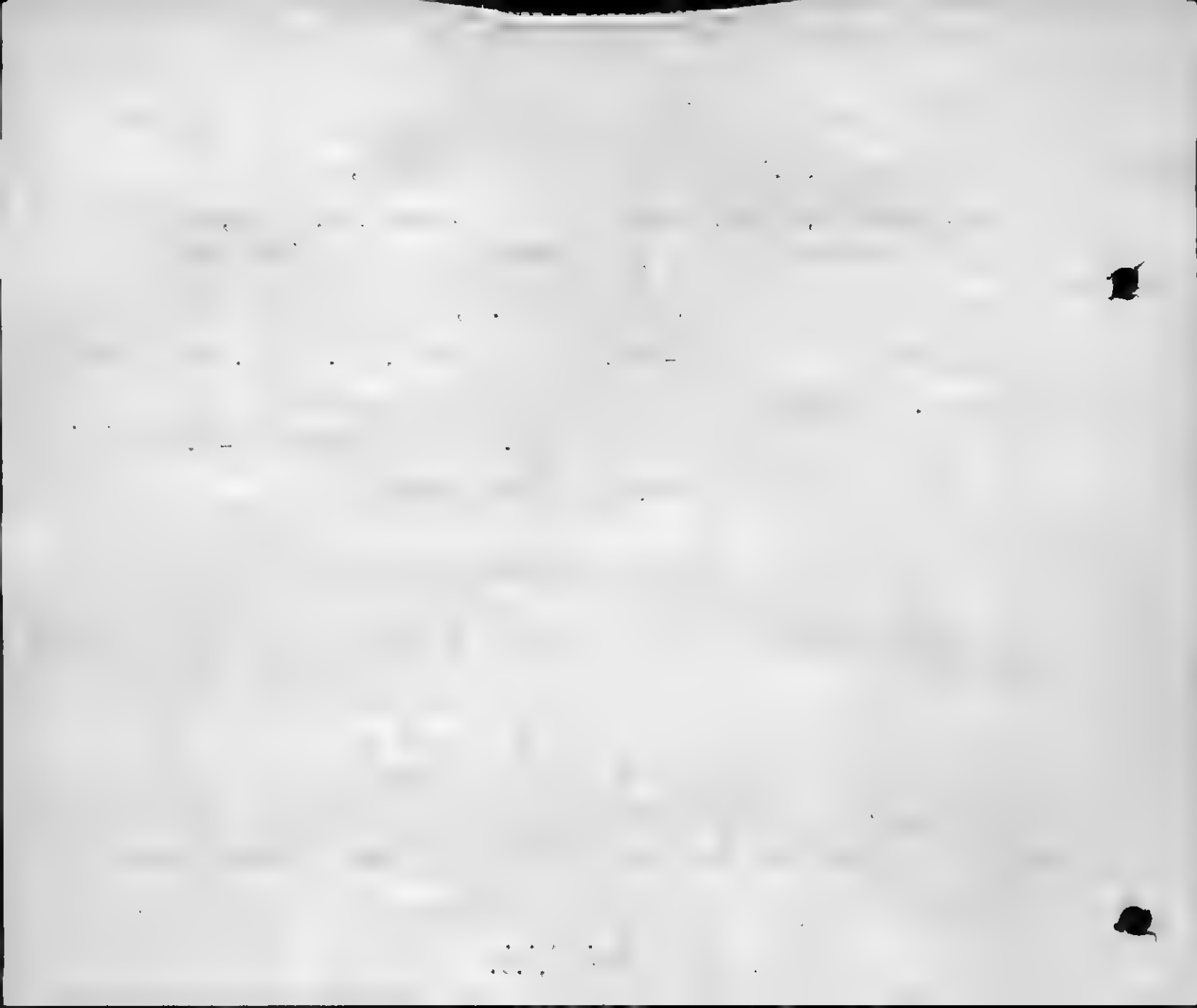
74171X 3



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card, papers, Pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

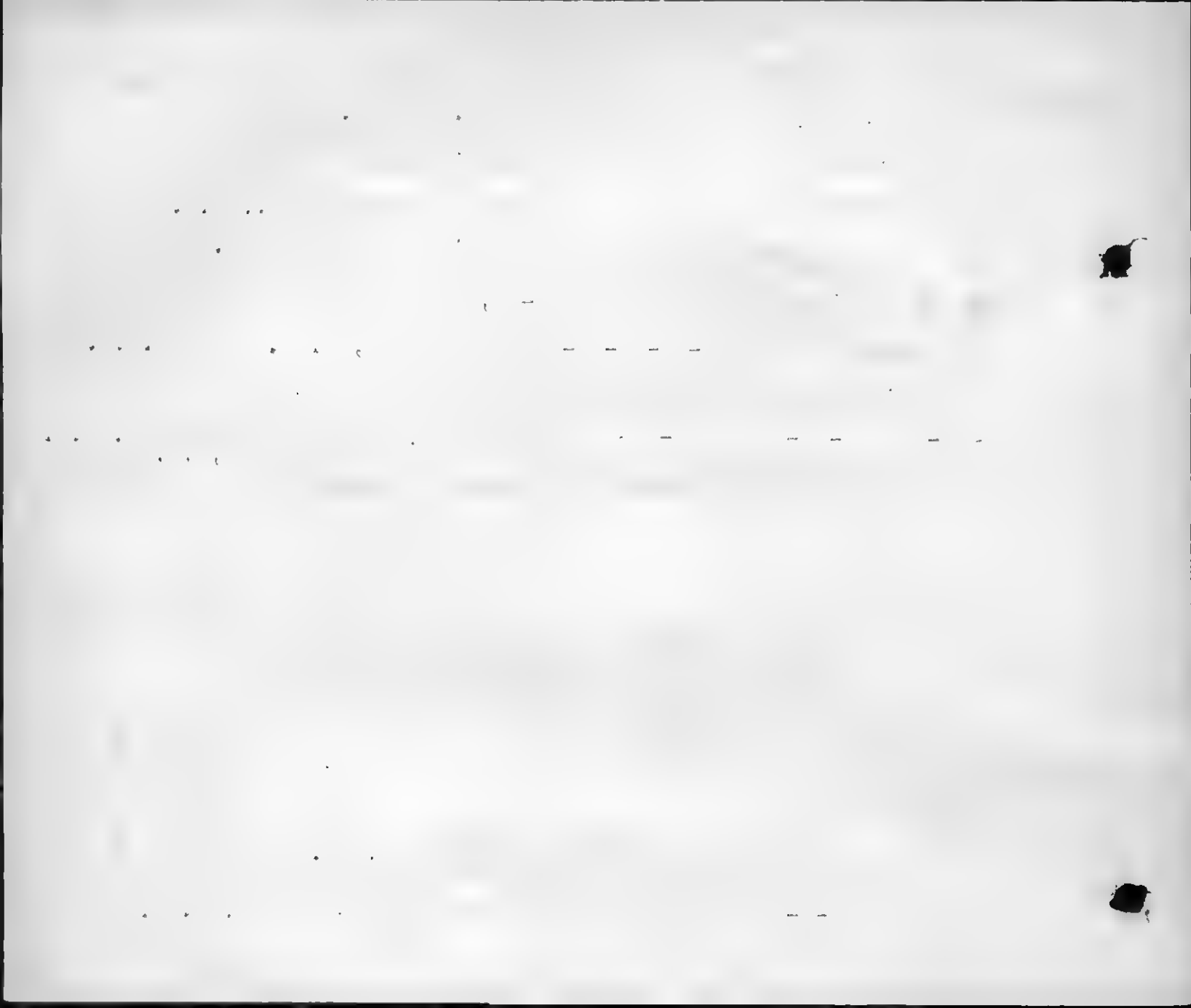
VR A15 (4)  
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |  |  |   |  |   |  |  |  |
|---|--|---|--|--|--|---|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |  |  |   |  |   |  |  |  |
| 1-184   |  |   |  |  |  |   |  |   |  |  |  |
| CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |   |  |  |  |
| 14154   |  |   |  |  |  |   |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY COUNTY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BETHESDA (KENWOOD, MD.)</b><br>c. LENGTH OF STAY IN 1b<br><b>YEARS</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>6416 SHADOW ROAD, KENWOOD, MARYLAND</b> |  |   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>MONTGOMERY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>KENWOOD</b><br><b>BETHESDA, MARYLAND</b><br>d. STREET ADDRESS<br><b>6416 SHADOW ROAD, KENWOOD, MARYLAND</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>LILLIAN L. MOSES</b>   |  |   |  |  |  | 4. DATE OF DEATH<br><b>Dec. 31 1961</b>   |  |   |  |  |  |
| 5. SEX<br><b>FEMALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>JAN. 25, 1884</b>  |  | 9. AGE (In years last birthday)<br><b>77</b> yrs.                                       |  | 10. IF UNDER 1 YEAR<br>Months <b>11</b> Days <b>6</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME-MAKER</b>   |  |   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>WASHINGTON, DIST. OF COL.</b> |  | 12. CITIZEN OF WHAT COUNTRY<br><b>UNITED STATES</b>    |  |
| 13. FATHER'S NAME<br><b>JAMES T. HOWENSTEIN</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>MARY WADE SULLIVAN</b>   |  |   |  | 17. INFORMANT (Daughter)<br><b>MRS. PATRICIA RICHARDS</b>                               |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>MARY WADE SULLIVAN</b>   |  |   |  | 17. INFORMANT (Daughter)<br><b>MRS. PATRICIA RICHARDS</b>                               |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>MARY WADE SULLIVAN</b>   |  |   |  | 17. INFORMANT (Daughter)<br><b>MRS. PATRICIA RICHARDS</b>                               |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>MARY WADE SULLIVAN</b>   |  |   |  | 17. INFORMANT (Daughter)<br><b>MRS. PATRICIA RICHARDS</b>                               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Cerebral Thrombosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br><b>Cerebral arteriosclerosis</b><br>(c)<br><b>6 mo.</b>  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>9 days</b>   |  |   |  |  |  |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Hypertensive - Cardiovascular disease</b>  |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  |   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)   |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)<br><b>July 27, 1961, to Dec. 30, 1961</b>   |  | 20g. (County)<br><b>Dec. 31, 1961</b>   |  | 20h. (State)<br><b>WASHINGTON, D.C.</b>                |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 27, 1961, to Dec. 30, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 30, 1961</b> , and that death occurred at <b>1206</b> M, from the causes and on the date stated above.  |  |   |  |  |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><b>Malcolm D. Harrison</b> M.D.   |  |   |  |  |  | 22b. DATE SIGNED<br><b>Dec. 31, 1961</b>  |  |   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>MALCOLM D. HARRISON</b>  |  |   |  |  |  | 22d. ADDRESS<br><b>4535 YUMA ST NW - WASH., D.C.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>CREMATION</b>   |  | 23b. DATE THEREOF<br><b>1/3/1962</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FORT LINCOLN CREMATORY</b>  |  | 23d. LOCATION (City, town or county)<br><b>PRINCE GEORGES, MARYLAND</b>   |  | 23e. REC'D BY REGISTRAR<br><b>JAN 3 1962</b>  |  | 23f. REGISTRAR'S SIGNATURE<br><b>Charles S. Thomas</b> |  |









# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14186

14156

|  |   |   |   |  |
|--|---|---|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MONTGOMERY</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u><br>c. LENGTH OF STAY (In 1b) <u>3 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>   |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u><br>d. STREET ADDRESS <u>1119 CLAGETT DR.</u> |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>BELVA M MULLINS</u>   |   | <b>4. DATE OF DEATH</b><br>Month <u>DEC.</u> Day <u>7</u> Year <u>19 61</u>   |   |  |
| <b>5. SEX</b><br><u>Female</u>   | <b>6. COLOR OR RACE</b><br><u>white</u> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br><u>4/12/14</u> | <b>9. AGE</b> (In years last birthday) <u>47</u> yrs.<br>IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>         |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>  |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>  |   | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>VIRGINIA</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>                  |
| <b>13. FATHER'S NAME</b><br><u>LEVI BOGGS</u>  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>GOLDIE BERRY</u>  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u><br>(If yes, give war or dates of service) <u>  </u>   |   | <b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>  |   | <b>17. INFORMANT</b><br><u>  </u>  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u><br>(b) <u>CEREBRAL ARTERIO SCLEROSIS</u><br>(c) <u>HYPERTENSION, INTERMEDIATE CAUSE</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>DIABETES MELLITUS</u> |   |   |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>4 DAYS</u><br><u>20 YEARS</u>  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>   |   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u><br><b>20f. (City or town)</b> (County) (State) <u>  </u> |
| <b>21. I certify that (I) (this hospital) attended the deceased from August 1961 to December 7, 1961, that (I) (we) last saw the deceased alive on December 7, 1961, and that death occurred at 11:00 A.M. from the causes and on the date stated above.</b>   |   |   |   |  |
| <b>22a. SIGNATURE</b><br><u>Gordon Rosenberg</u>   |   | <b>22b. DATE SIGNED</b><br><u>December 7, 1961</u>  |   |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>GORDON ROSENBERGER</u>   |   | <b>22d. ADDRESS</b><br><u>310 W. MONTG. AVE. ROCKVILLE, MD.</u>   |   |  |
| <b>23a. BURIAL, CREMATION, 23b. DATE THEREOF</b><br><u>BURIAL 12/10/62</u>   |   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Meade</u>   |   | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Pound, Virginia</u>  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Gordon Rosenberg</u>   |   | <b>25a. REC'D BY REGISTRAR</b><br><u>DEC 13 '61</u>   |   | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Kline</u>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon #2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14187

14157

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MONTGOMERY</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BROOKMONT</u><br>c. LENGTH OF STAY IN 1b <u>5 YRS</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4103 Maryland Ave.</u>  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKMONT</u><br>d. STREET ADDRESS <u>4103 Maryland Ave.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>Josephine Ellen Mutchler</u><br>First Middle Last   |  |   |  | <b>4. DATE OF DEATH</b> Month <u>Dec.</u> Day <u>20</u> Year <u>1961</u>  |  |   |  |
| <b>5. SEX</b> <u>Female</u>   |  | <b>6. COLOR OR RACE</b> <u>White</u>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b> <u>Nov. 8, 1875</u>   |  |
| <b>9. AGE</b> (In years last birthday) <u>86</u> yrs.   |  | <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>  |  | <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>  |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> |  |
| <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u>   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, D.C.</u>                            |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>   |  | <b>13. FATHER'S NAME</b> <u>William E. Burroughs</u>  |  |
| <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Alice Frizzell</u>  |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>                            |  | <b>16. SOCIAL SECURITY NO.</b> <u>None</u>  |  | <b>17. INFORMANT</b> <u>Ida Johnson, Sister, Same as #2</u><br>Address <u>  </u>                                    |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral vascular hemorrhage</u><br><u>331X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u><br>DUE TO (c) <u>Generalized arteriosclerosis</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> |  |   |  |   |  |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |  |   |  |   |  |   |  |
| <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>   |  |   |  |   |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>  </u>   |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>   |  | <b>20f. (City or town)</b> (County) (State) <u>  </u>   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>July 1958</u> <b>to</b> <u>Dec. 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>20 Dec. 1961</u> , <b>and that death occurred at</b> <u>8 P.M.</u> , <b>from the causes and on the date stated above.</b>   |  |   |  |   |  |   |  |
| <b>22a. SIGNATURE</b> <u>Andrew Tesitore</u>  |  |   |  | <b>22b. DATE SIGNED</b> <u>12-20-61</u>   |  |   |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b> <u>ANDREW TESITORE</u>  |  |   |  | <b>22d. ADDRESS</b> <u>114 Contham Rd. Silver Spring, Md.</u>   |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>  |  | <b>23b. DATE THEREOF</b> <u>Dec. 23, 1961</u>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Nat'l.</u>   |  | <b>23d. LOCATION (City, town or county)</b> (State) <u>Ft. Myer, Va.</u>  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W.W. Chambers Co.</u>  |  |   |  | <b>25a. REC'D BY REGISTRAR</b> <u>DEC 27 1961</u>   |  |   |  |
| <b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Haines</u>  |  |   |  | <b>25c. ADDRESS</b> <u>3072 M St. N.W. Wash., D.C.</u>  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

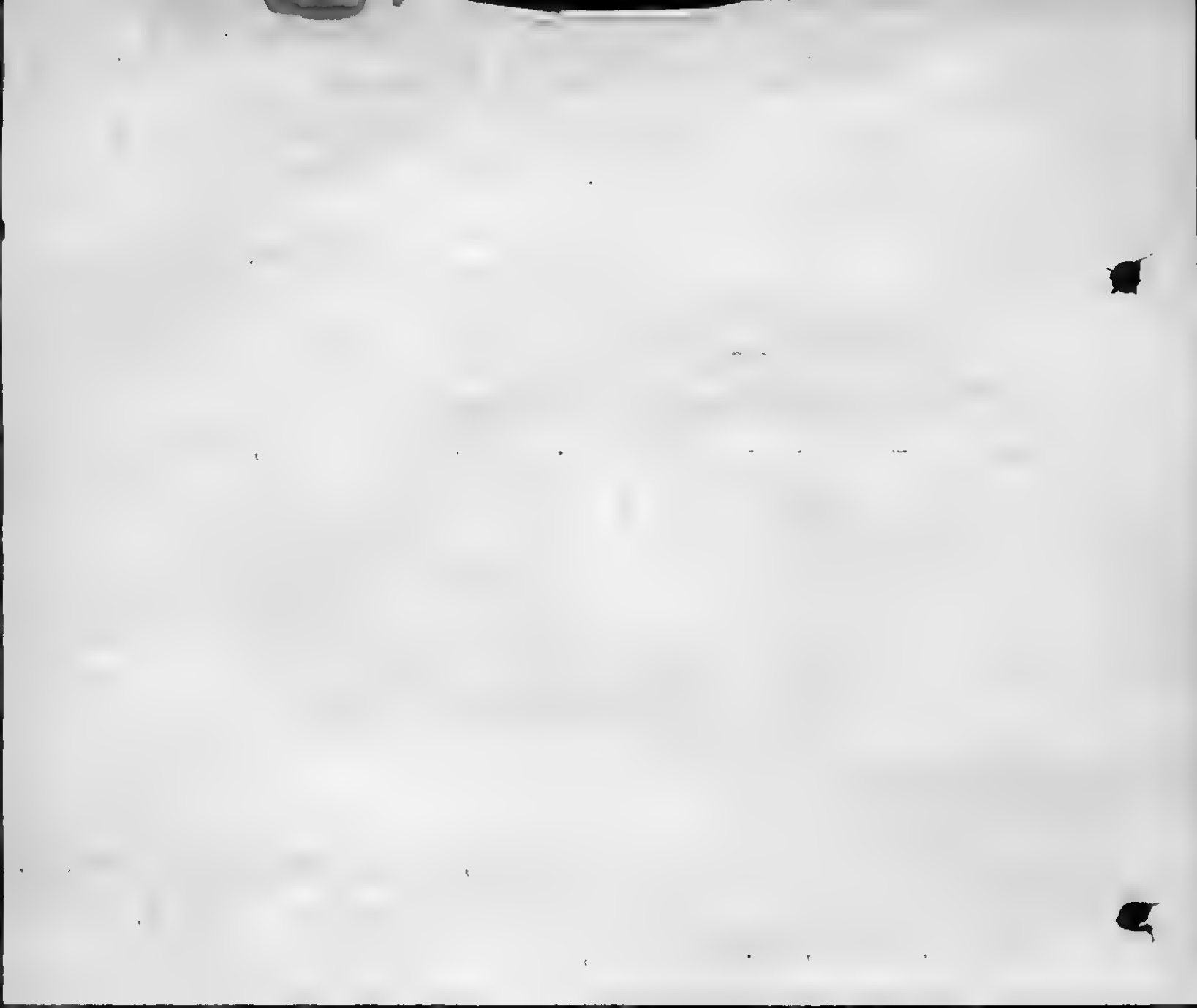
CERTIFICATE OF DEATH

14188

Items 13 & 14 Film G302 12/11/61 1wk

14158

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>OHIO</u> b. COUNTY <u>MONTGOMERY</u>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MONTGOMERY</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MONTGOMERY</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>  |  | d. STREET ADDRESS <u>216 ROYCE ST. URBANA</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last <u>OLIVE LEE MYERS</u>  |  | 4. DATE OF DEATH<br>Month Day Year <u>DEC. 3 1961</u>   |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>2/16/75</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXX HOMEMAKER</u>  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>OHIO</u>   |  |
| 13. FATHER'S NAME <u>Drew</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Sarah Jane Hart</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |  | 16. SOCIAL SECURITY NO. <u>XXXXXX</u>   |  |
| 17. INFORMANT <u>Mr. Clarence Myers</u>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Myocardial infarction, posterior wall</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>420.1</u><br>DUE TO<br>(c) <u>420.1</u> |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20. INTERVAL BETWEEN ONSET AND DEATH <u>About 10 days</u>   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 25</u> , 19 <u>61</u> , to <u>Dec 3</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Dec 3</u> , 19 <u>61</u> , and that death occurred at <u>3:25 AM</u> , from the causes and on the date stated above. |  | 22a. SIGNATURE <u>John J. Curry, M.D.</u>   |  |
| 22b. DATE SIGNED <u>Dec 3 1961</u>   |  | 22c. PHYSICIAN'S NAME (Type) <u>JOHN J. CURRY</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | 23b. DATE THEREOF <u>12/7/61</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN CEMETERY</u>  |  | 23d. LOCATION (City, town or county) (State) <u>SPRINGFIELD, CLARK CO. OHIO</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zick</u>  |  | 25a. REC'D BY REGISTRAR <u>DEC 6 '61</u>  |  |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>  |  | 25c. ADDRESS <u>8434 GEORGIA AVENUE SILVER SPRING, MARYLAND</u>   |  |





DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15  
FOR STATE  
HEALTH DEPT.

(M)

X

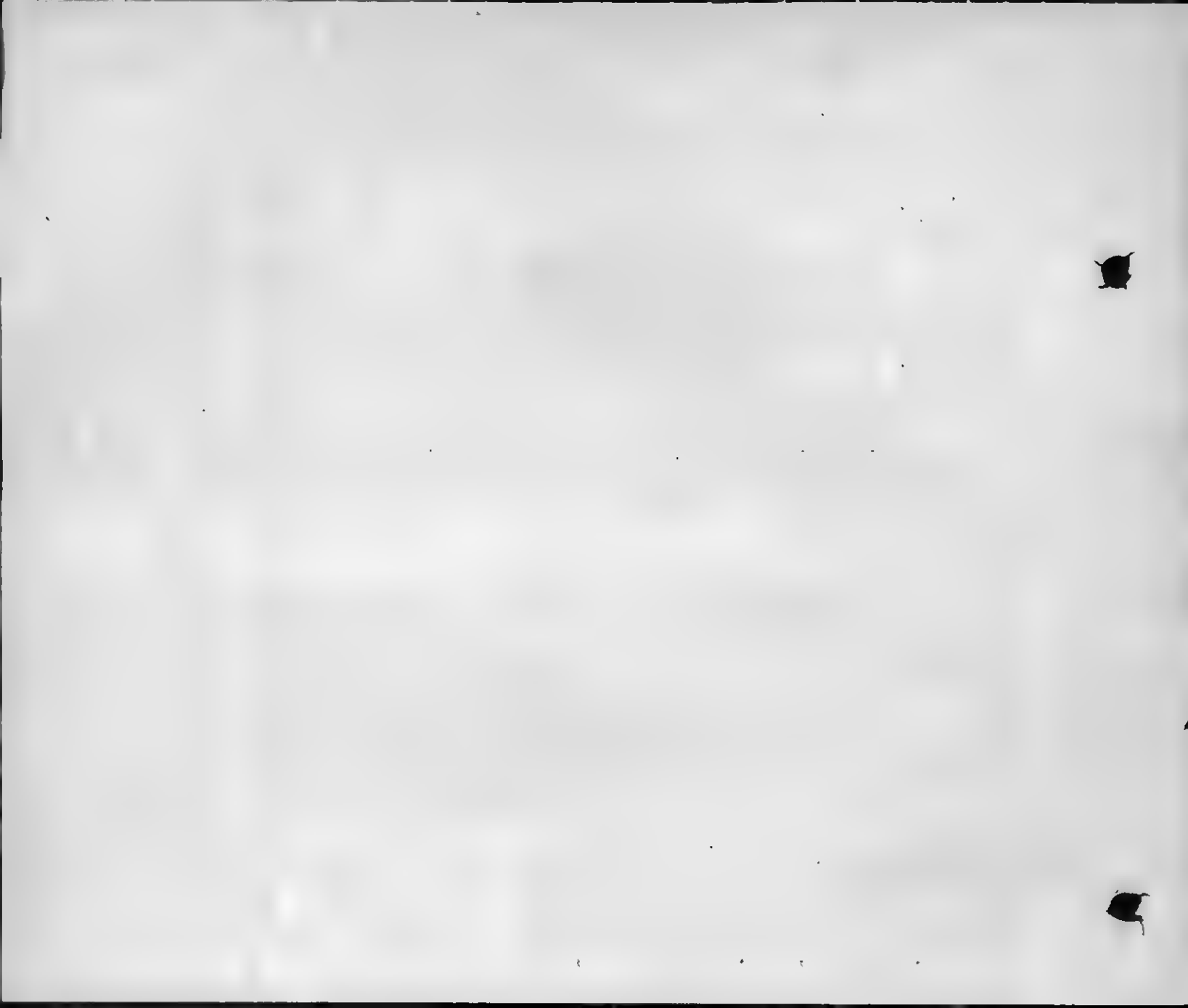
MEDICAL CERTIFICATION

1

2

3

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                               |  |   |  |  |  |  |  |   |  |
|---|--|-------------------------------|--|---|--|--|--|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                               |  |   |  |  |  |  |  |   |  |
| 14189 MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                               |  |   |  |  |  |  |  |   |  |
| 14159   |  |                               |  |   |  |  |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>  |  |                               |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>                     |  |  |  |  |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>   |  |                               |  | c. LENGTH OF STAY IN 1b <u>5 yrs</u>  |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4515- Gridley Rd.</u>   |  |                               |  | d. STREET ADDRESS <u>4515- Gridley Rd.</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>James Retichum Nekhmen</u>   |  |                               |  | 4. DATE OF DEATH <u>Dec. 18</u>   |  |  |  | 9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u> |  |   |  |
| 5. SEX <u>male</u>  |  | 6. COLOR OR RACE <u>white</u> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 8. DATE OF BIRTH <u>1-15-1890</u>                                      |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>plumber</u>                                   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>PLUMBING</u> |  |
| 13. FATHER'S NAME <u>John Nekhmen</u>   |  |                               |  | 14. MOTHER'S M maiden name <u>Elinor Raymond</u>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  |                               |  | 16. SOCIAL SECURITY NO. <u>---</u>  |  |  |  | 17. INFORMANT <u>Edith Gilbert (daughter)</u> Address <u>Slime 2</u>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                               |  |   |  |  |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u><br>DUE TO (c)   |  |                               |  |   |  |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                               |  |   |  |  |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)  |  |  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  |                               |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                               |  |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u>  |  |                               |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  | DATE SIGNED <u>12-18-61</u>  |  |   |  |
| EXAMINER'S NAME (Type) <u>FRANK J. BROSCART</u>   |  |                               |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                               |  | 22b. DATE THEREOF <u>12/21/61</u>   |  |  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Cypress Hills</u>  |  |   |  |
| 22d. LOCATION (City, town, or country) (State)  |  |                               |  | 22e. LOCATION (City, town, or country) (State)  |  |  |  | 22f. LOCATION (City, town, or country) (State)   |  |   |  |
| 23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u> 8434 Georgia Avenue  |  |                               |  | 24b. REC'D BY REGISTRAR <u>DEC 22 '61</u>   |  |  |  | 24c. REGISTRAR'S SIGNATURE <u>W. S. Turner</u>   |  |   |  |
| Warner E. Pumphrey, Inc. Silver Spring, Maryland  |  |                               |  | DATE  |  |  |  |  |  |   |  |



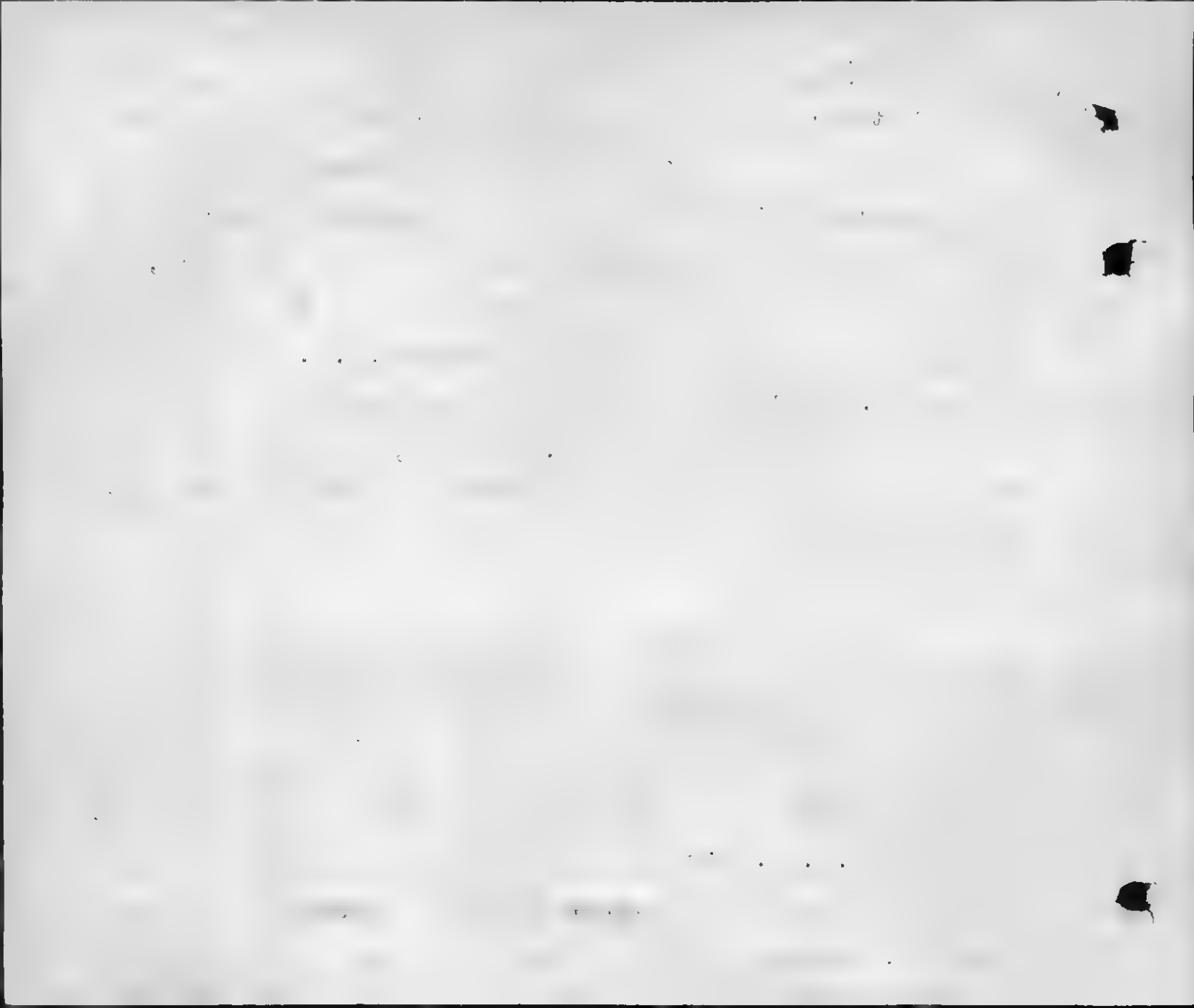
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and send it to the funeral home. Carbon 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

VR A15 (4)  
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AP

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                  |  |   |  |                                     |  |   |  |   |  |
|---|--|----------------------------------|--|---|--|-------------------------------------|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                  |  |   |  |                                     |  |   |  |   |  |
| CERTIFICATE OF DEATH  |  |                                  |  |   |  |                                     |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b>  |  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)<br>a. STATE <b>Maryland</b>   |  |                                     |  | b. COUNTY <b>Montgomery</b>   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  |                                  |  | c. LENGTH OF STAY IN 1b<br><b>27 days</b>   |  |                                     |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>47 Chevy Chase</b>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Suburban Hospital</b>  |  |                                  |  | d. STREET ADDRESS<br><b>5124 Bradley Boulevard</b>  |  |                                     |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Louise Newkirk Nelson</b>  |  |                                  |  | 4. DATE OF DEATH<br><b>December 7, 1961</b>   |  |                                     |  | 5. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>11/26/09</b> |  | 9. AGE (In years last birthday)<br><b>52 yrs.</b>   |  | 10. IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>19</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Washington, D. C.</b>   |  |                                     |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>Francis M. Newkirk</b>  |  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Verda Hughes</b>   |  |                                     |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  |   |  |
| 16. SOCIAL SECURITY NO<br><b>no</b>   |  |                                  |  | 17. INFORMANT<br><b>M. Cary Nelson, husband same as above</b>   |  |                                     |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Carcinoma of breast with widespread metastases</b><br>170X DUE TO (b) <b>170X</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <b>170X</b> |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>Constrictive heart failure</b>  |  |                                  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                     |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)<br><b>11-10-1961 to 12-7-1961</b>                                |  |                                     |  | 20c. TIME OF INJURY<br>Month, Day, Year<br><b>19</b>  |  |   |  |
| 20d. INJURY OCCURRED<br>White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>   |  |                                  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>6719 Wilson Lane, Beth. Md.</b>  |  |                                     |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11-10-1961</b> to <b>12-7-1961</b> , that (I) (we) last saw the deceased alive on <b>12-7-1961</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above. |  |                                  |  | 22a. SIGNATURE<br><b>Stephen W. Dejter</b> M.D.   |  |                                     |  | 22b. DATE SIGNED<br><b>12/7/61</b>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. S. Wm. Dejter</b>  |  |                                  |  | 22d. ADDRESS<br><b>6719 Wilson Lane, Beth. Md.</b>  |  |                                     |  | 22e. REC'D BY REGISTRAR<br><b>Robert A. Pumphrey</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                                  |  | 23b. DATE THEREOF<br><b>12/11/61</b>  |  |                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>  |  |   |  |
| 23d. LOCATION (City, town or county)<br><b>Rockville, Maryland</b>  |  |                                  |  | 23e. REGISTRAR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>   |  |                                     |  | 23f. DATE<br><b>DEC 13 '61</b>  |  |   |  |



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|  |  |  |   |
|--|--|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> MARYLAND   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution. Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Montg</u>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Wheaton</u> SILVER SPRING   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Wheaton</u>   |   |
| c. LENGTH OF STAY IN 1b<br><u>12 yrs</u>   |  | d. STREET ADDRESS<br><u>11801 Judson Rd</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>11801 Judson Rd</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br><u>Ollie Ethel Newcomb</u>  |  | 4. DATE OF DEATH<br>Day <u>Dec</u> Month <u>6</u> Year <u>1961</u>   |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>1-1-1893</u>   |
| 9. AGE (In years last birthday)<br><u>68</u> yrs   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housework</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>OWN HOME</u>   | 11. BIRTHPLACE (State or foreign country)<br><u>Pa</u>  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>   | 13. FATHER'S NAME<br><u>W. G. Smith</u>  | 14. MOTHER'S MAIDEN NAME<br><u>Margaret O'Brien</u>  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><u>NO</u> |
| 16. SOCIAL SECURITY NO.<br><u>NONE</u>   | 17. INFORMANT<br><u>Ernest Combe - Son</u>   | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral occlusion</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____<br>(c) _____ |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. _____ p.m. _____  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) _____ (County) _____ (State) _____  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> |  |  |   |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 22b. DATE THEREOF <u>12/9/61</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>FORT LINCOLN CEMETERY</u>   |  | 22d. LOCATION (City, town, or country) <u>PRINCE GEORGE'S MARYLAND</u>   |   |
| 23. FUNERAL DIRECTOR<br><u>Raymond A. Ziska</u>  |  | 24a. REC'D BY REGISTRAR <u>DEC 8 '61</u>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><u>S. S. K...</u>  |  | 24c. REGISTRAR'S SIGNATURE   |   |



1  
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14192

14162

### PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

c. LENGTH OF STAY IN 1b

29 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF DECEASED (Type or print)

First

Mary

Middle

Ellen

Last

Nicholson

4. DATE OF DEATH

Month

Day

Year

December 28, 1961

5. SEX

Female

6. COLOR OR RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐

DIVORCED ☐

8. DATE OF BIRTH

November 15, 1930

9. AGE (In years last birthday)

31 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Schenectady, N.Y.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Bryant Halsey

14. MOTHER'S MAIDEN NAME

Emma Blaise

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

111-28-5579

17. INFORMANT

HUS: William Nicholson, Same as #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Mitral Stenosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)

Rheumatic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

7 yrs

16 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from Nov. 30, 1961, to Dec. 28, 1961, that (we) last saw the deceased alive on Dec. 28, 1961, and that death occurred 11:35 AM from the causes and on the date stated above.

22a. SIGNATURE

C. W. BRAM LETT

M.D.

ATTENDING PHYS. ☐

MED. DIRECTOR ☐

STAFF PHYS. ☒

22b. DATE SIGNED Dec. 28, 1961

22c. PHYSICIAN'S NAME (Type)

C. W. BRAM LETT LT MC USN

22d. ADDRESS

U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

12-30-61

23c. NAME OF CEMETERY OR CREMATORY

Arlington National

23d. LOCATION (City, town or county)

Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE

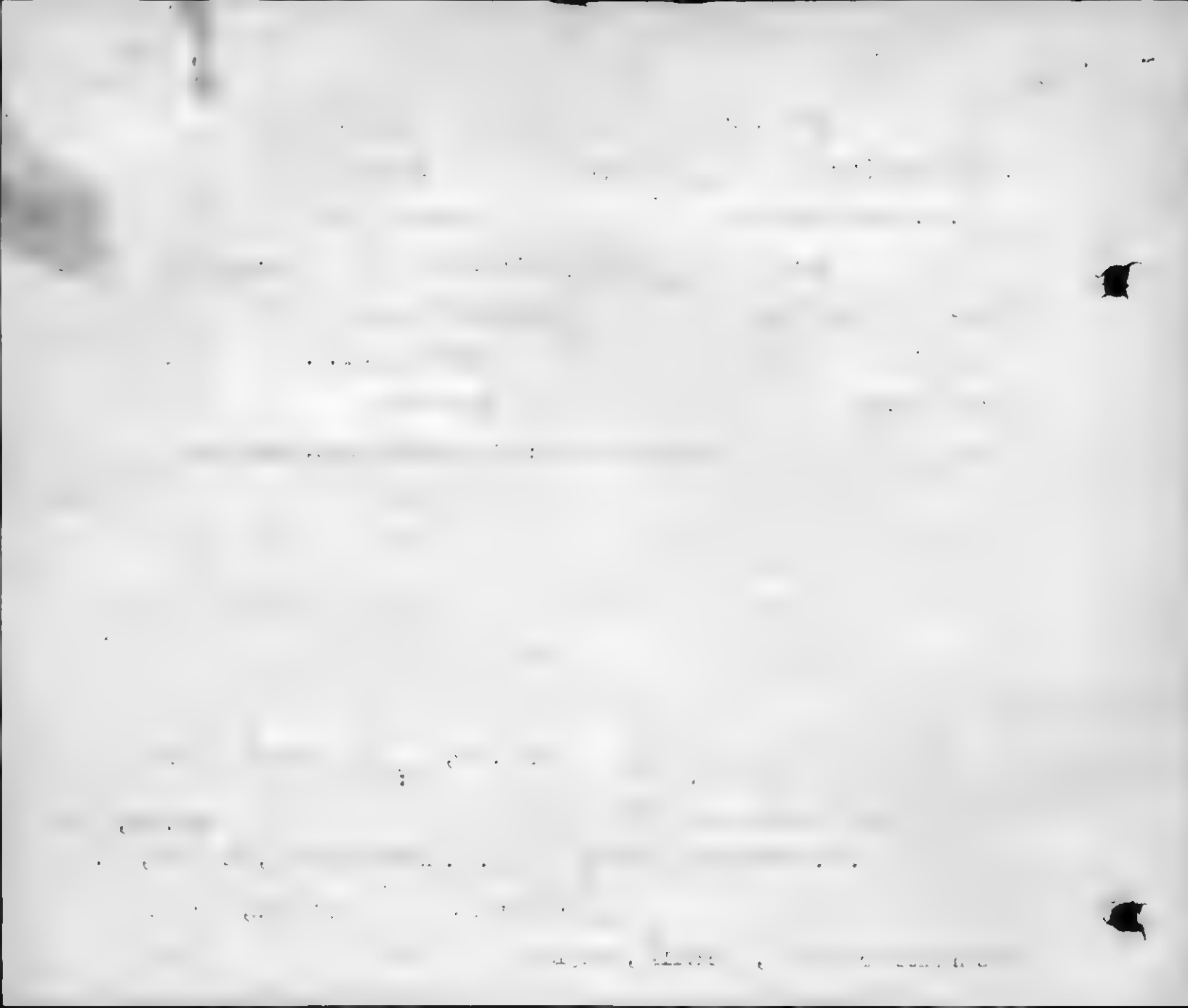
Tyson Wheeler Funeral, Rockville, Maryland

25a. REC'D BY REGISTRAR

DAUAN 2 '62

25b. REGISTRAR'S SIGNATURE

William S. Thomas





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |   |  |   |  |   |  |   |  |
| 14193 CERTIFICATE OF DEATH 14163  |  |   |  |   |  |   |  |   |  |   |  |
| Date 7/10/1961 File # 324-40  |  |   |  |   |  |   |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery  |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>olney |  | c. LENGTH OF STAY IN 1b<br>1 day  |  | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>Montgomery General Hospital |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE<br>Maryland<br>b. COUNTY<br>Howard<br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Highland<br>d. STREET ADDRESS |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)  |  | First<br>Ellen Virginia O'Brien   |  | Middle<br>Last  |  | 4. DATE OF DEATH<br>Month<br>12<br>Day<br>6<br>Year<br>19 61  |  | 5. SEX<br>female  |  | 6. COLOR OR RACE<br>white   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br>8/12/1900   |  | 9. AGE (in years last birthday)<br>61 yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>housewife     |  | 11. BIRTHPLACE (County & State, or foreign country)<br>New Jersey   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 13. FATHER'S NAME<br>William Bowker   |  | 14. MOTHER'S MAIDEN NAME<br>Cora May Golden   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give year or dates of service)<br>no |  | 16. SOCIAL SECURITY NO.<br>Hospital Records   |  | 17. INFORMANT<br>Address  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremia &amp; Anemia</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Acute Chronic pyelonephritis</u><br>(c) <u>3 days</u><br>DUE TO<br>cause last. (c) <u>3 mo</u> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NA. DISEASE CONDITION GIVEN IN PART I (a).  |  |   |  |   |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  |   |  |   |  |   |  |   |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of item 1b)   |  |   |  |   |  |   |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br>19  |  |   |  |   |  |   |  |   |  |   |  |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |   |  |   |  |   |  |   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |   |  |   |  |   |  |   |  |   |  |
| 20f. (City or town) (County) (State)  |  |   |  |   |  |   |  |   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from 2/3/1960 to 12/6/1961, that (I) (we) last saw the deceased alive on 12/6/1961, and that death occurred at 6:50 PM, from the causes and on the date stated above.      |  |   |  |   |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br>22b. DATE SIGNED<br>12/8/61   |  |   |  |   |  |   |  |   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br>Dr. Charles Ligon<br>M.D.<br>ATTENDING PHYS. <input checked="" type="checkbox"/><br>MED. DIRECTOR <input type="checkbox"/><br>STAFF PHYS. <input type="checkbox"/><br>22d. ADDRESS<br>Sandy Spring, Md. |  |   |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  |   |  |   |  |   |  |   |  |   |  |
| 23b. DATE THEREOF<br>12-9-61  |  |   |  |   |  |   |  |   |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>GATE OF HEAVEN WHEATON, Md  |  |   |  |   |  |   |  |   |  |   |  |
| 23d. LOCATION (City, town or county) (State)  |  |   |  |   |  |   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>HC Rignathorn 100 W. C. C. 4th  |  |   |  |   |  |   |  |   |  |   |  |
| 25a. REC'D BY REGISTRAR<br>DATE 1/61  |  |   |  |   |  |   |  |   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br>C. H. S. Smith  |  |   |  |   |  |   |  |   |  |   |  |



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

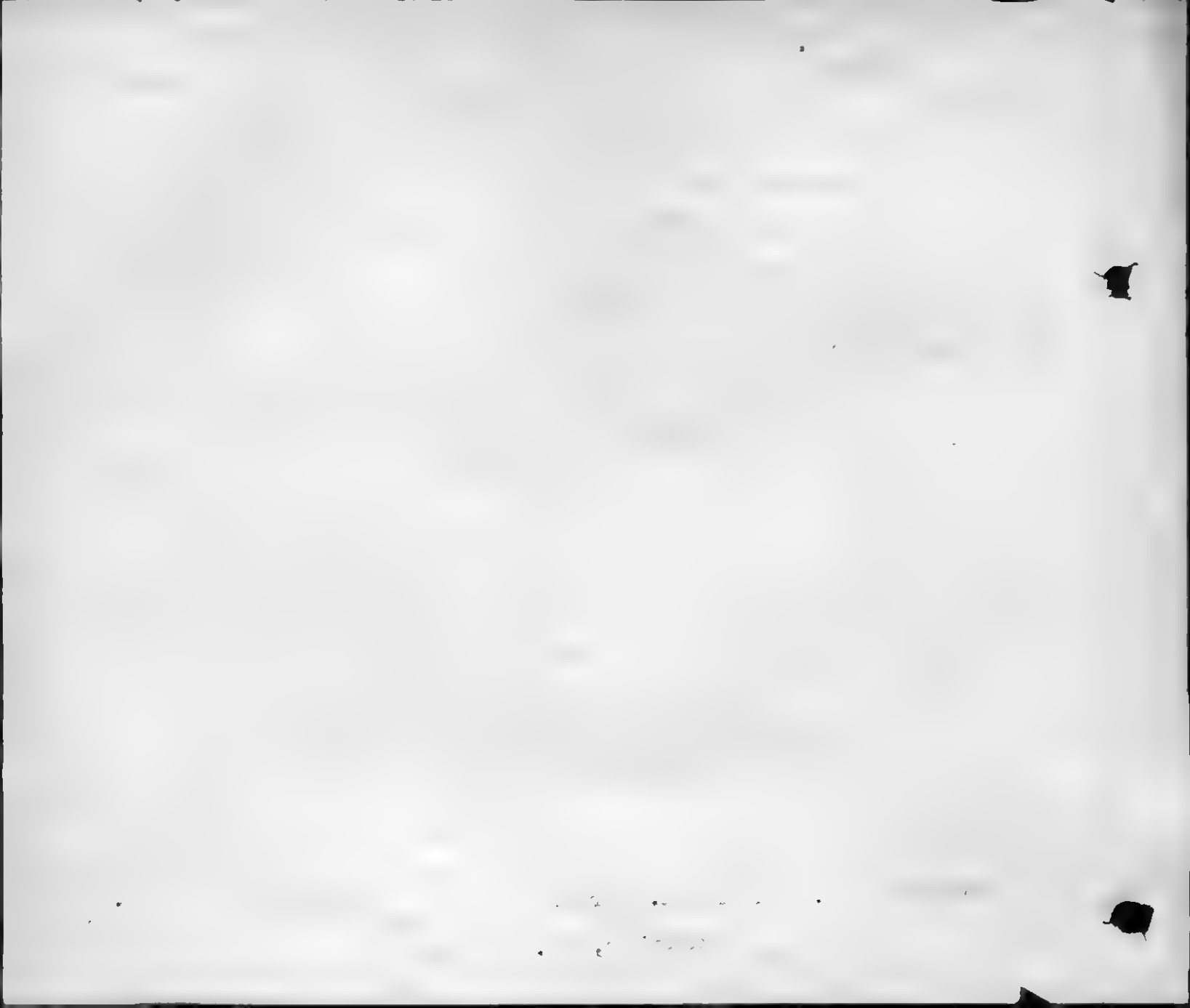
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14194

14164

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Mont. County</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney, Md.</u><br>c. LENGTH OF STAY IN 1b <u>7 yrs.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brooke Grove Foundation</u> |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before adm'ssion)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brookeville, Md.</u><br>d. STREET ADDRESS <u>Brookeville, Md.</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>Carrie</u><br>First Middle Last<br>4. DATE OF DEATH <u>DEC. 26 1961</u><br>Month Day Year   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>1872</u><br>Year   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (in years last birthday) <u>89</u> yr. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min. |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Fred. Co. Md.</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>  |  |
| 13. FATHER'S NAME <u>David Specht</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Aurelia Kessler</u><br>Address <u>Margaret O. Howes Olney Md.</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)   |   | 16. SOCIAL SECURITY NO. <u>None</u>  |  |
| 17. INFORMANT <u>Margaret O. Howes Olney Md.</u>   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremia</u><br><u>450.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Chronic pyelonephritis</u><br>(c) <u>Arteriosclerosis</u> DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) <u>General</u> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct 12/12</u> to <u>12/26</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.  |   |  |  |
| 22a. SIGNATURE <u>C. H. Bigon</u><br>M.D.  |   | 22b. DATE SIGNED <u>12/26/61</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>C. H. Bigon</u>  |   | 22d. ADDRESS <u>Sandy Spring, Md.</u>  |  |
| 23a. BURIAL, CREMATION, <u>Burial</u> (Specify)  | 23b. DATE THEREOF <u>Dec. 29 1961</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>   | 23d. LOCATION (City, town or county) (State) <u>Montgomery Md.</u>                                     |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u><br>ADDRESS <u>Laytonsville, Md.</u>  |   | 25a. REC'D BY REGISTRAR <u>DA DEC 29 '61</u>   |  |
|  |   | 25b. REGISTRAR'S SIGNATURE <u>Arthur J. Kessler</u>  |  |

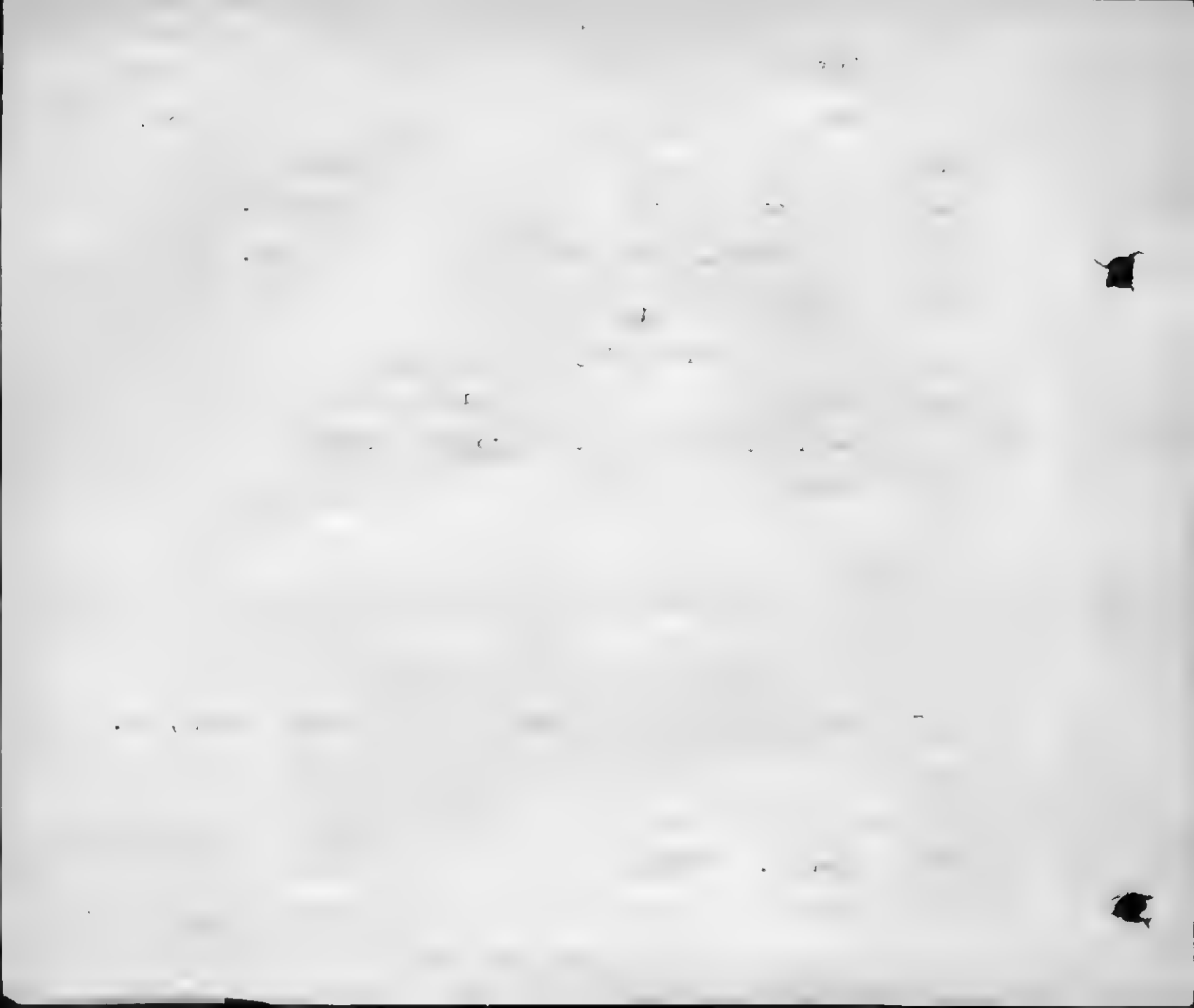


1  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. In any delay is necessary, the funeral director, Page 1, 2, and 3, should be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |  |   |  |  |  |
| 14195 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14165   |  |  |  |  |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b>   |  |  | b. COUNTY<br><b>Montgomery</b>  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Olney</b>  |  |  | c. LENGTH OF STAY IN TB<br><b>DOA</b>  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>14 Silver Spring</b>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Montgomery General Hospital</b>  |  |  | d. STREET ADDRESS<br><b>14350 Good Hope Rd.</b>  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>MICHAEL HUMPHREY O'LEARY</b>  |  |  | 4. DATE OF DEATH<br><b>Dec. 17 19 61</b>   |  |  | 5. SEX<br><b>Male</b>   |  |  |  |
| 6. COLOR OR RACE<br><b>white</b>  |  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                       |  |  | 8. DATE OF BIRTH<br><b>1/22/04</b>  |  |  |  |
| 9. AGE (In years last birthday)<br><b>57</b> yrs.   |  |  | 10. AGE (In years last birthday)<br><b>57</b> yrs.   |  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Ireland</b>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Landscaping</b>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Landscaping</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  |
| 13. FATHER'S NAME<br><b>Michael O'Leary</b>   |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Julia O'Brien</b>   |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes Second W.W. 216-01-9953</b>   |  |  |  |
| 16. SOCIAL SECURITY NO.<br><b>Second W.W. 216-01-9953</b>   |  |  | 17. INFORMANT<br><b>Hospital Records</b>   |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemorrhage</b><br>DUE TO (b) <b>Rupture of aorta</b><br>DUE TO (c) <b>Ductal</b> |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br><b>Shot in chest with 22 Cal. Rifle</b>          |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Shot in chest with 22 Cal. Rifle</b>   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br><b>5:30 p.m. 12/17/61</b>   |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>   |  |  |  |
| 20f. (City or town)<br><b>Silver Spring, Md.</b>  |  |  | 20g. (County)<br><b>Silver Spring, Md.</b>   |  |  | 20h. (State)<br><b>Silver Spring, Md.</b>   |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  | CHIEF MEDICAL EXAMINER<br><b>Frank J. Broschart</b>  |  |  | DATE SIGNED<br><b>12/18/61</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 22b. DATE THEREOF<br><b>12/21/61</b>   |  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |  |  |  |
| 22d. LOCATION (City, town, or country)<br><b>Arlington, Va.</b>   |  |  | 22e. (State)<br><b>Arlington, Va.</b>  |  |  | 22f. REC'D BY REGISTRAR<br><b>DEC 21 '61</b>  |  |  |  |
| 22g. REGISTRAR'S SIGNATURE<br><b>Francis Gasch's Sons Hyattsville, Maryland</b>   |  |  | 22h. REGISTRAR'S SIGNATURE<br><b>Francis Gasch's Sons Hyattsville, Maryland</b>  |  |  | 22i. REGISTRAR'S SIGNATURE<br><b>Francis Gasch's Sons Hyattsville, Maryland</b>   |  |  |  |



## CERTIFICATE OF DEATH

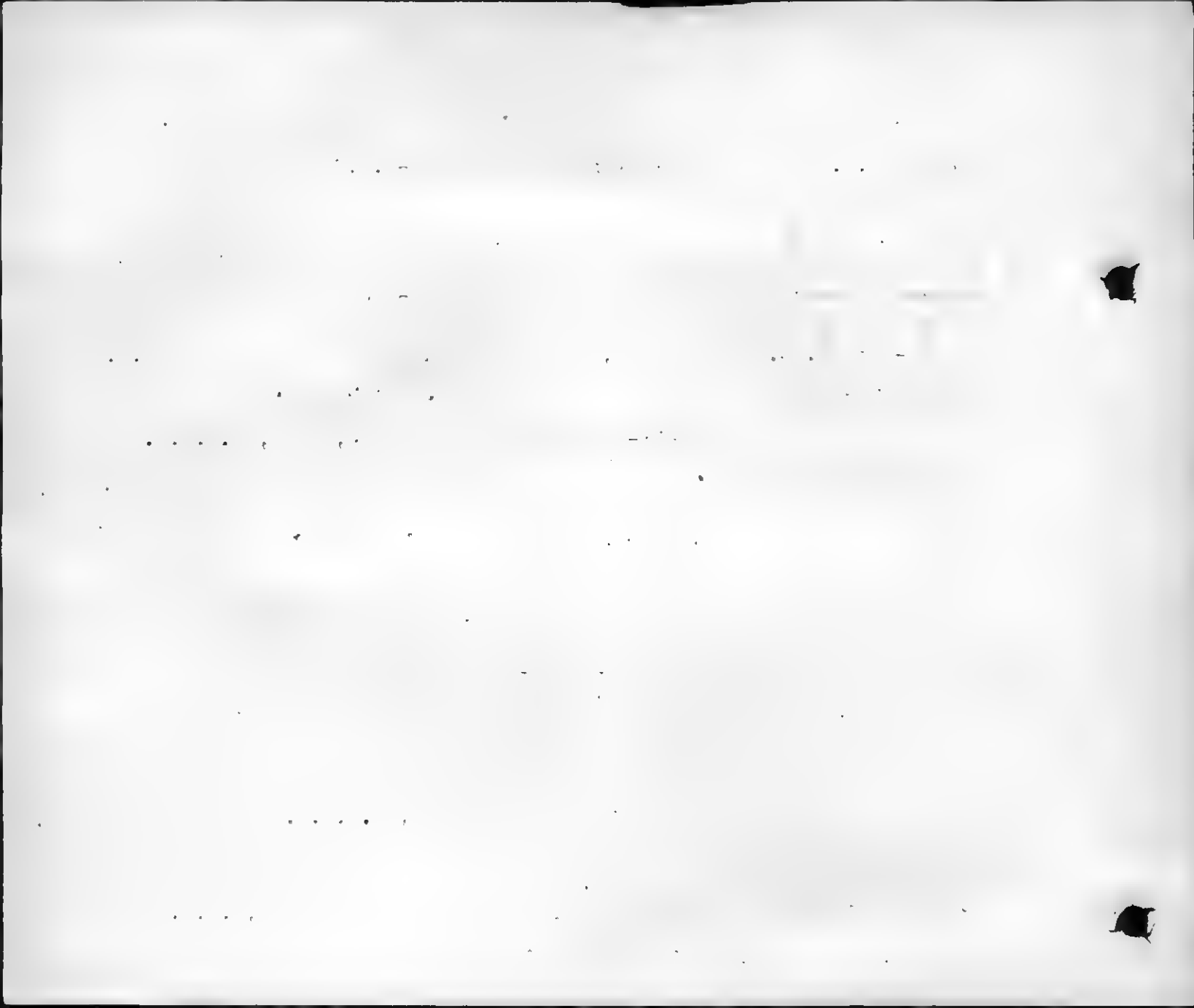
Reg. Dist. No.

1-166

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Boyd's--R.F.D.</b>   |                               | c. LENGTH OF STAY IN 1b<br><b>10 yrs</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <b>Hillebrand</b> First Middle Last <b>CLTHUIS</b>  |                               | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>24</b> Year <b>1961</b>   |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 15-1908</b>                     |
| 9. AGE (In years last birthday) <b>53</b> yrs.  |                               | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk--Montg. Co. School Board, Md</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Holland</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.</b>  |                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 13. FATHER'S NAME<br><b>Tgaart Olthuis</b>  |                               | 14. MOTHER'S MAIDEN NAME<br><b>Klaasji Van Dalen</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO.<br><b>215-38-4689</b>  |  |
| INFORMANT<br><b>Mrs Mary Simpson, Boyd's, Md. R.F.D.</b>  |                               | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary edema</b><br><b>1621</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Bronchogenic carcinoma</b> DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days - 6 months</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day Year<br>Hour o. m. _____ p. m. _____ 19  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, b.d.g., etc.)  |                               | 20f. (City or town) _____ (County) _____ (State) _____   |  |
| 21. I certify that I attended the deceased from <b>12 Dec 1961</b> to <b>24 Dec 1961</b> , that I lost s/he the deceased alive on <b>23 Dec 1961</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Boyd's, Md. R.F.D.</b> DATE SIGNED <b>12/24/61</b>   |                               |  |  |
| ACTUAL SIGNATURE <b>John Fawcett</b> M.D.   |                               | PHYSICIAN'S NAME (Type) <b>John Fawcett</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                               | 22b. DATE THEREOF<br><b>12/26/61</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Flower Hill Cemetery</b>   |                               | 22d. LOCATION (City, town, or county) (State)<br><b>Deerwood, R.F.D. Maryland</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>William B. Hillon</b>  |                               | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 28 '61</b>  |  |
| ADDRESS<br><b>Barnesville, Md</b>   |                               | 24b. REGISTRAR'S SIGNATURE<br><b>William B. Hillon</b>   |  |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

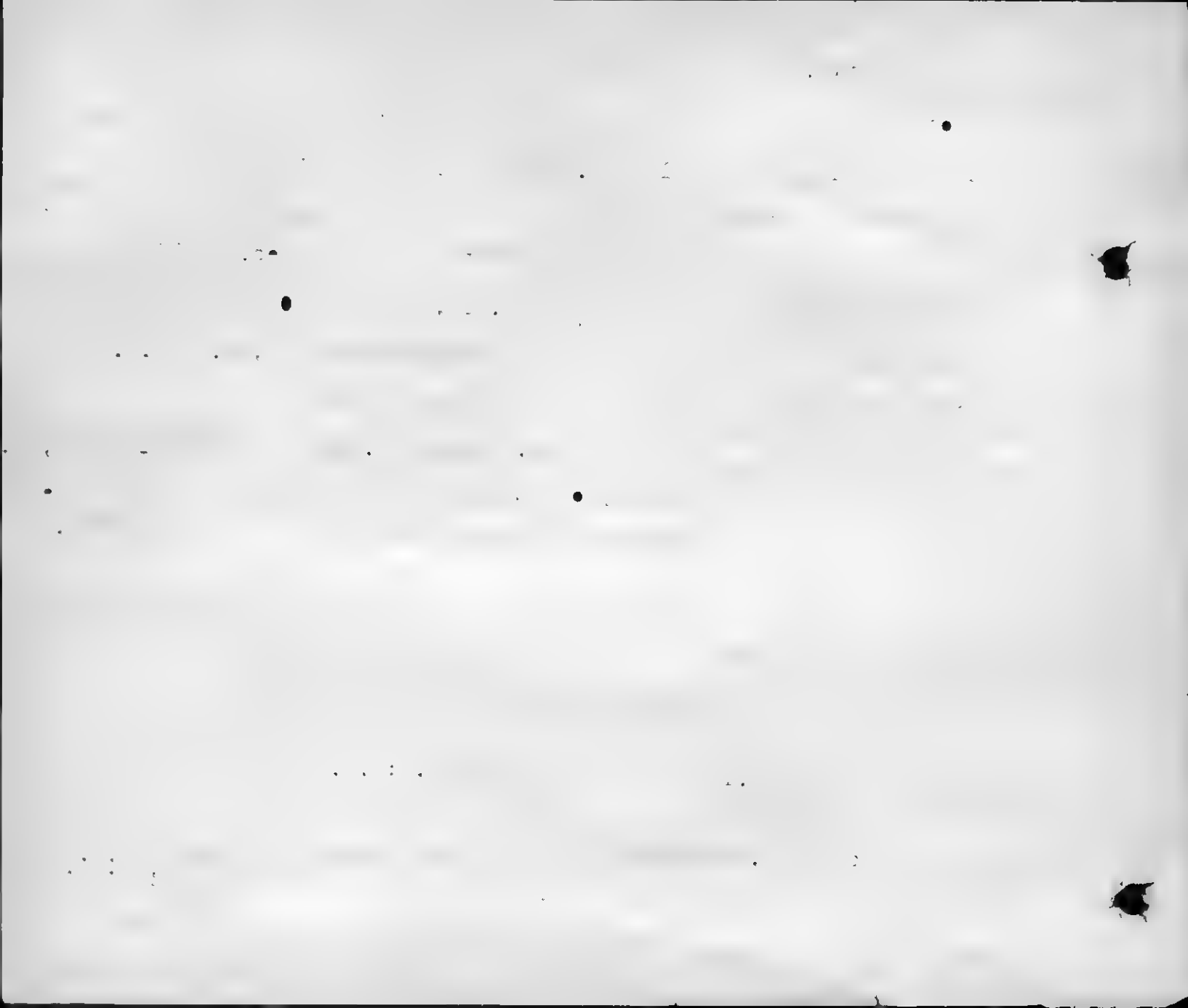
## CERTIFICATE OF DEATH

14197

14167

|  |   |   |  |
|--|---|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                          |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>  |  |
| c. LENGTH OF STAY IN TB <u>18 yrs.</u>   |   | d. STREET ADDRESS <u>805 Thayer Avenue</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>805 Thayer Avenue</u>   |   |   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><u>Emma Irene Osbourn</u>   |   | <b>4. DATE OF DEATH</b><br>Day <u>12</u> Month <u>Dec.</u> Year <u>1961</u>   |  |
| <b>5. SEX</b><br><u>Female</u>   | <b>6. COLOR OR RACE</b><br><u>White</u>         | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b> <u>1881 Oct. 15, 1961</u>                        |
| <b>9. AGE</b> (In years last birthday) <u>80 yrs.</u>  |   | <b>10. IF UNDER 1 YEAR</b> Months <u>8</u> Days <u>12</u>   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Montgomery County, Md.</u>  |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.</u>  |  |
| <b>13. FATHER'S NAME</b><br><u>John Boswell</u>  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Maria Clarke</u>  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>   |   | <b>16. SOCIAL SECURITY NO.</b> <u>None</u>  |  |
| <b>17. INFORMANT</b><br><u>Dr. Raymond A. Osbourn</u>  |   | <b>Address</b> <u>8204 Kerry Road Chevy Chase 15, Md.</u>   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>(b) <u>Hypertensive heart disease</u><br>(c) <u>420.1</u><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)   |   |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |
| <b>20c. TIME OF INJURY</b><br>Hour <u>19</u> a.m. <u>p.m.</u>  |   | <b>20d. INJURY OCCURRED</b><br>White <input type="checkbox"/> Not White <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>         |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |   | <b>20f. (City or town)</b> (County) (State)   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>146</u> <b>to</b> <u>Dec 12, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Aug. 16, 1961</u> , <b>and that death occurred</b> <u>approx. 6:30 a.m.</u> <b>from the causes and on the date stated above.</b>                      |   |   |  |
| <b>22a. SIGNATURE</b><br><u>Michael J. McInerney</u>   |   | <b>22b. DATE SIGNED</b><br><u>Dec 12, 1961</u>  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Michael J. McInerney</u>   |   | <b>22d. ADDRESS</b><br><u>1150 Connecticut Avenue, N.W. Washington, D.C.</u>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>BURIAL</u>  | <b>23b. DATE THEREOF</b><br><u>Dec 14, 1961</u> | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>MT. OLIVET</u>  | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>WASH. D.C.</u> |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>WWTaltanull</u>  |   | <b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b><br><u>DEC 15 '61</u>   |  |

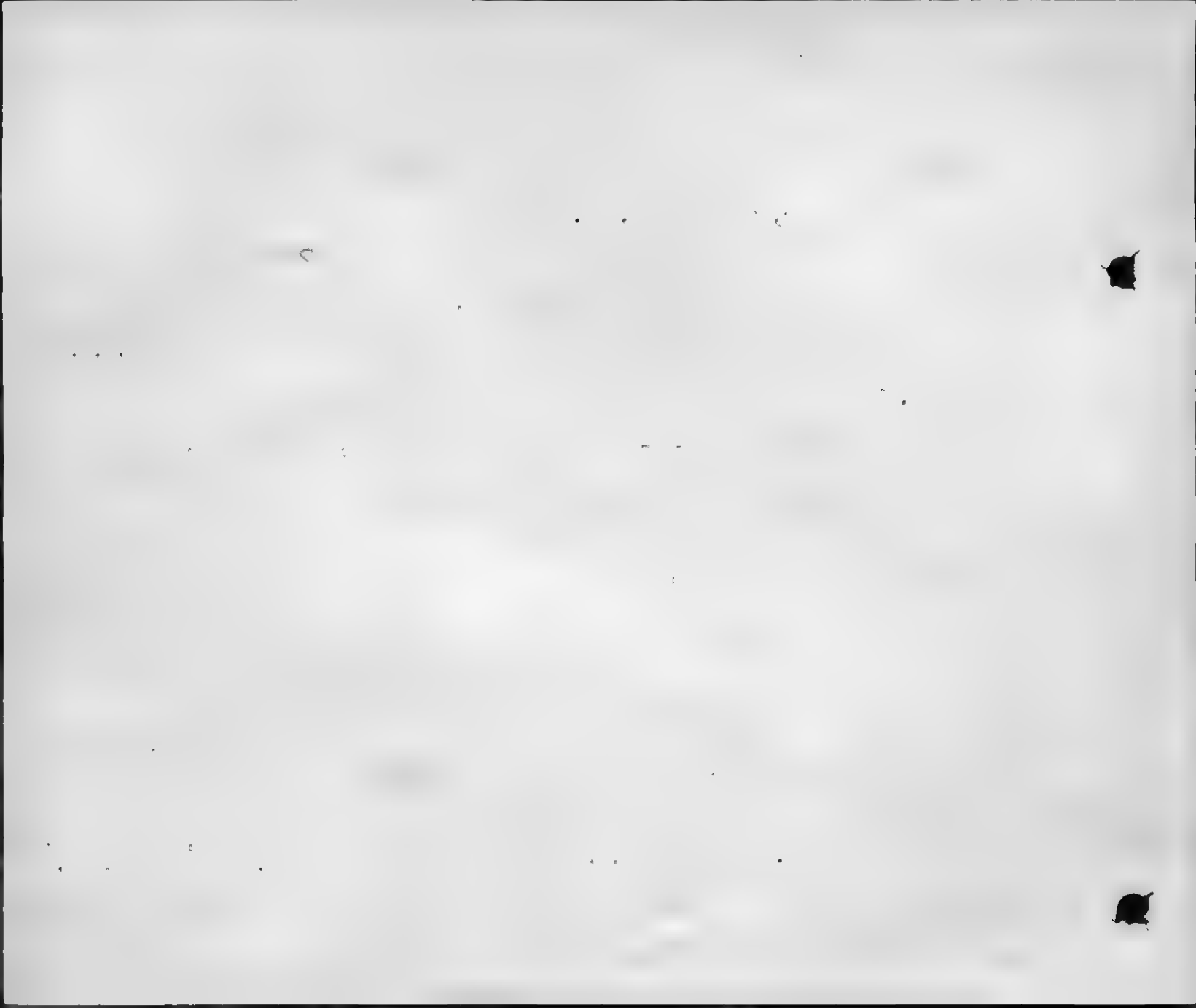
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

|  |  |                           |  |   |  |   |  |   |  |  |  |
|--|--|---------------------------|--|---|--|---|--|---|--|--|--|
| 14198  |  |                           |  |   |  |   |  |   |  |  |  |
| M  |  |                           |  |   |  |   |  |   |  |  |  |
| 11/4/62  |  |                           |  |   |  |   |  |   |  |  |  |
| 14168  |  |                           |  |   |  |   |  |   |  |  |  |
| Items 4, 21, 8, 22, Film G304 1/4/62 iwk   |  |                           |  |   |  |   |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery   |  |                           |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>Maryland<br>b. COUNTY<br>Prince Georges  |  |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda   |  |                           |  |   |  | c. LENGTH OF STAY IN IL<br>52 days  |  |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>The Clinical Center, Bethesda 14, Md.  |  |                           |  |   |  | d. STREET ADDRESS<br>4214 Guilford Drive  |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Suzanne (No middle name) Packard   |  |                           |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br>December 30 19 61   |  |   |  |  |  |
| 5. SEX<br>Female   |  | 6. COLOR OR RACE<br>White |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>April 1, 1929   |  | 9. AGE (In years last birthday)<br>32 yrs.                          |  | 10. UNDER 1 YEAR<br>Months Days<br>19 61 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Physical Therapist  |  |                           |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>(Unemployed)   |  |   |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Pennsylvania |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 13. FATHER'S NAME<br>Harold E. Bemis   |  |                           |  |   |  | 14. MOTHER'S MAIDEN NAME<br>Hazel Mae Harwood   |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch and service)<br>No NONE   |  |                           |  |   |  | 16. SOCIAL SECURITY NO<br>533-24-7679   |  |   |  |  |  |
| 17. INFORMANT<br>The Medical Record  |  |                           |  |   |  | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiovascular collapse<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Pseudomonas septicemia<br>DUE TO<br>(c) Hodgkin's Disease<br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>Congestive heart failure |  |   |  |  |  |
| 19. INTERVAL BETWEEN ONSET AND DEATH<br>5 minutes<br>6 days<br>6 months  |  |                           |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                           |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Hour a.m.<br>p.m.   |  | Month. Day. Year<br>19    |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)   |  | (County) (State)                         |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 8, 1961, to December 30, 1961, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 30, 1961, and that death occurred at 10:05 P.M., from the causes and on the date stated above. |  |                           |  |   |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br>Edward S. Henderson, M.D.  |  |                           |  |   |  | 22b. DATE SIGNED<br>January 1, 1962   |  | 22c. PHYSICIAN'S NAME (Type)<br>Edward S. Henderson, M.D.           |  |  |  |
| 22d. ADDRESS<br>The Clinical Center, National Institutes of Health, Bethesda 14, Md.   |  |                           |  |   |  | 22e. REC'D BY REGISTRAR<br>DATE JAN 4 '62   |  |   |  |  |  |
| 22f. REGISTRAR'S SIGNATURE<br>W.W. Chambers, Inc. Silver Spring, Md.   |  |                           |  |   |  | 22g. REGISTRAR'S SIGNATURE<br>W.W. Chambers, Inc. Silver Spring, Md.  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, or other disposal (Specify)<br>Burial 1/3/62   |  |                           |  |   |  | 23b. DATE THEREOF<br>1/3/62   |  |   |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Fort Lincoln Cem   |  |                           |  |   |  | 23d. LOCATION (City, town or county) (State)<br>Colmar Manor Arago, Md.   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>W.W. Chambers, Inc. Silver Spring, Md.   |  |                           |  |   |  | 24b. ADDRESS<br>Silver Spring, Md.  |  |   |  |  |  |
| 24c. DATE<br>JAN 4 '62   |  |                           |  |   |  | 24d. REGISTRAR'S SIGNATURE<br>W.W. Chambers, Inc. Silver Spring, Md.  |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

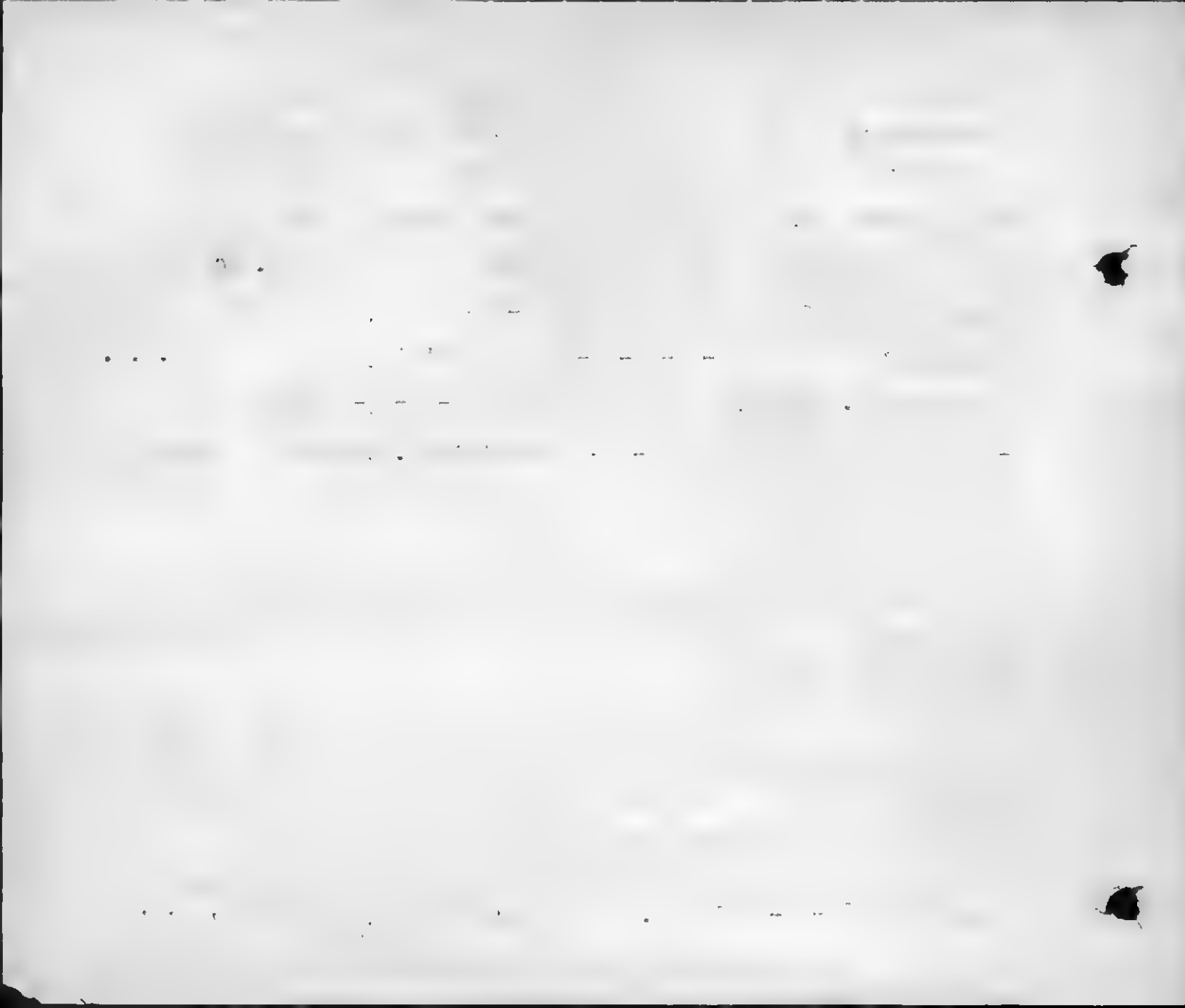
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14199

## CERTIFICATE OF DEATH

14169

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)<br><b>Sumner</b><br>c. LENGTH OF STAY IN It<br><b>5011 Randall Lane</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>5011 Randall Lane</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if instituton; Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sumner</b><br>d. STREET ADDRESS<br><b>5011 Randall Lane</b><br>• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>LORETTA M PALMER</b>   | 4. DATE OF DEATH<br><b>Dec. 26 19 61</b>  | 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>12-11-1879</b>   | 9. AGE (In years last birthday)<br><b>82</b> yrs.  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |
| 11b. KIND OF BUSINESS OR INDUSTRY<br><b>- - - -</b>   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 13. FATHER'S NAME<br><b>Edward L. Mahoney</b>  |
| 14. MOTHER'S MAIDEN NAME<br><b>Larkin</b>   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>- - - -</b> | 16. SOCIAL SECURITY NO.<br><b>- - - -</b>  | 17. INFORMANT<br><b>Virginia P. Mather (Daughter)</b>  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)<br><b>42.1</b> DUE TO<br><b>Cerebral myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.<br>DUE TO<br><b>- Cerebral infarction</b><br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>- Cerebral infarction</b> |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)                               | 20c. TIME OF INJURY<br>Hour a.m. _____ p.m. _____<br>Month, Day, Year<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)<br><b>Washington, D.C.</b>  | (County)   | (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 15, 1961</b> to <b>Dec. 26, 1961</b> that (I) (we) last saw the deceased alive on <b>Dec. 24, 1961</b> , and that death occurred at <b>10:00 A.M.</b> from the causes and on the date stated above.   |   |  |  |
| 22a. SIGNATURE<br><b>Frank A. Finnerty, Jr. M.D.</b>  | 22b. DATE SIGNED<br><b>Dec 26 1961</b>  | 22c. PHYSICIAN'S NAME (Type)<br><b>Frank A. Finnerty, Jr. M.D.</b>   | 22d. ADDRESS<br><b>1150 Conn. Ave., NW Wash DC</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>12-28-1961</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>   | 23d. LOCATION (City, town or county) (State)<br><b>Washington, D.C.</b>  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph Gaudin</b>  | 25a. REC'D BY REGISTRAR<br><b>DEC 28 '61</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>C. J. S. Hanna</b>  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

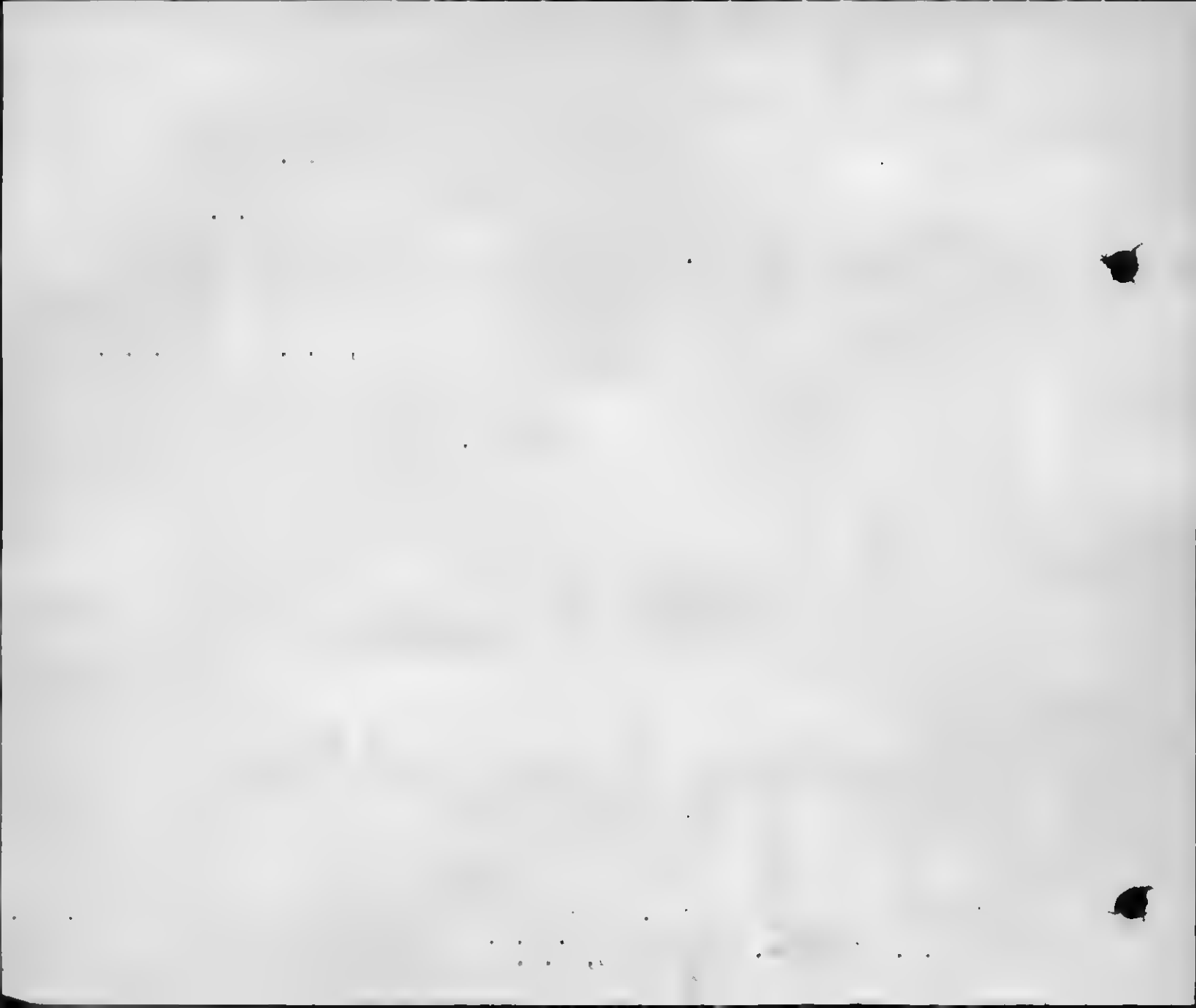
## CERTIFICATE OF DEATH

14200

14170

|  |  |   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|---|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN lb<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eventide Nursing Home</u> |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>e. STATE <u>D.C.</u> <span style="float: right;">b. COUNTY</span><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u><br>d. STREET ADDRESS <u>2853 Ontario Road N.W.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>SADE D. BARTRIDGE</u>   |  | <b>4. DATE OF DEATH</b><br>Month <u>December</u> Day <u>24</u> Year <u>1961</u> |  | <b>5. SEX</b><br><u>female</u>  |  | <b>6. COLOR OR RACE</b><br><u>white</u>                                 |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b><br><u>7/3/72</u> |  | <b>9. AGE</b> (In years last birthday) <u>89</u> yrs. <b>IF UNDER 1 YEAR</b><br>Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b><br>Hours <u>  </u> Min. <u>  </u> |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, D.C.</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>   |  |   |  | <b>13. FATHER'S NAME</b><br><u>Harrison Dingman</u><br><b>14. MOTHER'S MAIDEN NAME</b><br><u>Sarah Porter Hudson</u>  |  |   |  |  |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> <b>16. SOCIAL SECURITY NO.</b> <u>  </u> <b>17. INFORMANT</b><br><u>Lloyd L. Stone</u> <span style="float: right;">Address <u>same as #2</u></span>   |  |   |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br>DUE TO <u>  </u><br>Conditions, if any, which gave rise to immediate cause (b) <u>  </u><br>(a), stating the underlying cause last. <u>  </u><br>DUE TO <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>   |  |   |  |  |  |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  | <b>20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/><br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) <u>  </u><br><b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u> |  |   |  |  |  |   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from Jan 5, 1949, to Dec 24, 1961, that (I) (we) last saw the deceased alive on Dec 24, 1961, and that death occurred at 4:45 P.M. from the causes and on the date stated above.</b>   |  |   |  |   |  |   |  |  |  |   |  |
| <b>22a. SIGNATURE</b><br><u>Thomas S. Sappington</u> M.D.<br><b>22c. PHYSICIAN'S NAME</b> (Type) <u>Thomas S. Sappington</u>   |  |   |  | <b>22b. DATE SIGNED</b><br><u>Dec. 24, 1961</u><br><b>22d. ADDRESS</b><br><u>1025 CONNECTICUT AVE. NW</u>   |  |   |  |  |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>  |  | <b>23b. DATE THEREOF</b><br><u>12/26/61</u>                                     |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Ft. Lincoln Crematory Prince Georges County, Md.</u>  |  | <b>23d. LOCATION</b> (City, town or county) <u>  </u> (State) <u>  </u> |  |  |  |   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>The S.H. Hines Co.</u> <u>2901 14th St. N.W.</u><br><u>Washington, D.C.</u>  |  |   |  | <b>25a. REC'D BY REGISTRAR</b><br><u>DEC 27 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b><br><u>  </u>  |  |   |  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the funeral director, Page 1, 2, and 3, should be retained for your files. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 1882-2 Film 305  
1-4-62

305 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11171

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda  
c. LENGTH OF STAY in 1b 1 1/2 mo  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10007 Belhaven Rd

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE MD b. COUNTY Montg  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Bethesda  
d. STREET ADDRESS 10007 Belhaven Rd

3. NAME OF DECEASED (Type or print) Betty Jean Patterson  
4. DATE OF DEATH Dec 29 1961  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 8-24-32 9. AGE (In years last birthday) 29 yrs. IF UNDER 1 YEAR: Months 29 Days 29 Hours 29 Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse 10b. KIND OF BUSINESS OR INDUSTRY N.I.H. 11. BIRTHPLACE (State or foreign country) Tenn. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME H. M. PATTERSON 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 888.9 17. INFORMANT Father Address H.M. PATTERSON Jackson, Tenn.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) synergistic poisoning  
DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pheno-barbital & ethyl alcohol  
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 39 20d. INJURY OCCURRED While ☐ Not While ☐ at work et work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE Frank J. Broschart M.D. DATE SIGNED 12-29-61  
EXAMINER'S NAME (Type) FRANK J. BROSCHE Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 22b. DATE THEREOF 12-30-61 22c. NAME OF CEMETERY OR CREMATORY Hollywood Cemetery 22d. LOCATION (City, town, or country) (State) Jackson, Tenn.

23. FUNERAL DIRECTOR ROBERT A. PUMPHREY ADDRESS Bethesda, Md. 24a. REC'D BY REGISTRAR JAN 2 '62 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14172

1  
FOR STATE  
HEALTH DEPT.

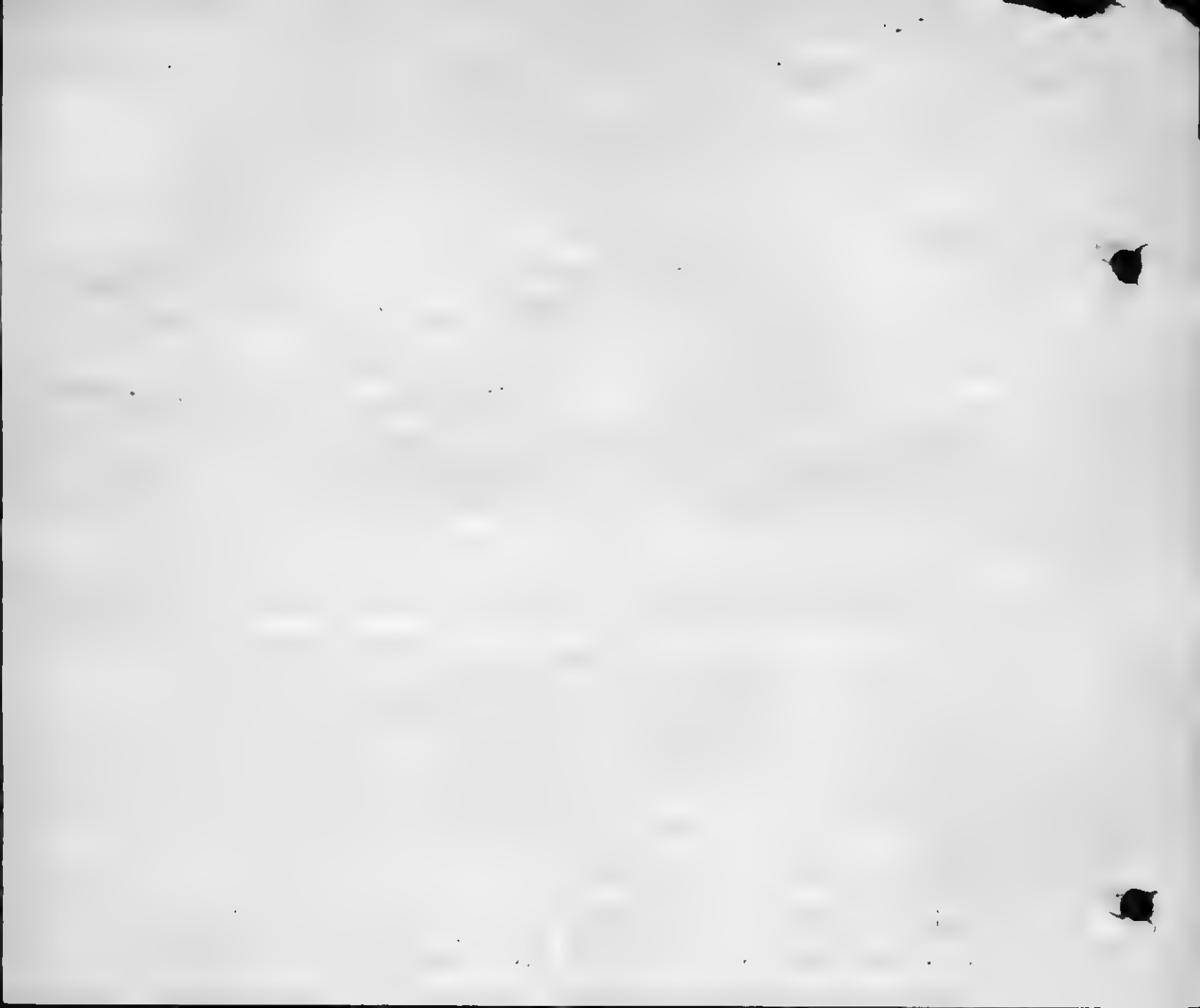
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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #M3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Ind.</u> b. COUNTY <u>P. g.</u> |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>                                    |  |
| c. LENGTH OF STAY in 1b <u>D.O.A.</u>   |  | d. STREET ADDRESS <u>4403 39th St</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7500 Brookville Rd</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 3. NAME OF DECEASED (Type or print) <u>Clifton E Pilcher</u>  |  | 4. DATE OF DEATH <u>Dec 14 1961</u>  |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OF RACE <u>white</u>  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <u>Sept. 30, 1911</u>   |  |
| 9. AGE (In years last birthday) <u>50</u> yrs.  |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handscaping</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Handscaping</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>   |  |
| 13. FATHER'S NAME <u>George H. Pilcher</u>  |  | 14. MOTHER'S M maiden name <u>Willie Mae Shent</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>  |  | 16. SOCIAL SECURITY NO. <u>218-038205</u>  |  |
| 17. INFORMANT <u>Charles Pilcher</u>  |  | Address <u>4403 - 39th St. Brentwood, Md.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u><br>DUE TO (b) <u>Coronary Occlusion</u><br>DUE TO (c) <u>Ruptured Atherosclerotic Plaque</u>  |  | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u><br><u>Sudden</u><br><u>Unknown</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                               |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Brosen</u>   |  | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Brosen</u>   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. LOCATION (City, town, or country) (State)   |  |
| 22c. NAME OF CEMETERY OR CREMATION <u>Burial Dec. 19, 1961 Fort Lincoln Cemetery</u>  |  | 22d. LOCATION (City, town, or country) (State) <u>Bladensburg, Maryland.</u>   |  |
| 23. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO.</u>  |  | 24a. REC'D BY REGISTRAR <u>DEC 18 '61</u>  |  |
| ADDRESS <u>517 11th St. S.E., Wash., D.C.</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Carhart L. Thomas</u>  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14203

## CERTIFICATE OF DEATH

14173

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>  |   | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>  |   |
| e. LENGTH OF STAY IN 1b <u>62 days</u>  |   | f. STREET ADDRESS <u>123 W Middle Lane</u>   |   |
| 3. NAME OF DECEASED (Type or print) <u>WICKLIFF H Pollen</u>  |   | 4. DATE OF DEATH <u>Dec. 14, 1961</u>  |   |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/24/1899</u>                                       |
| 9. AGE (In years last birthday) <u>62</u> yrs.  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Green Keeper Country Club</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>VA</u>  | 12. CITIZEN OF WHAT COUNTRY? <u>USA Yes</u>                             |
| 13. FATHER'S NAME <u>WICKLIFF Pollen</u>  | 14. MOTHER'S MAIDEN NAME <u>Annie Reeves</u>  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |   |
| 16. SOCIAL SECURITY NO <u>420-38619</u>   |   | 17. INFORMANT <u>Edith Pollen (wife)</u> Address <u>Same</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>155.1</u> DUE TO <u>Carcinoma of Ampulla of Vater + Duodenum with generalized metastases.</u><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>155.1</u> DUE TO (c) <u>155.1</u> |   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>61</u> to <u>Dec</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/13</u> , 19 <u>61</u> , and that death occurred at <u>12/14/61</u> M, from the causes and on the date stated above.   |   |  |   |
| 22a. SIGNATURE <u>Arthur F. Woodward</u> M.D.   |   | 22b. DATE SIGNED <u>12/14/61</u>   | 22c. PHYSICIAN'S NAME (Type or print) <u>Arthur F. Woodward</u>         |
| 22d. ADDRESS <u>Rockville, Maryland</u>   |   | 22e. REC'D BY REGISTRAR  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF <u>12/16/61</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Frederick Memorial Park</u>  | 23d. LOCATION (City, town or county) (State) <u>Frederick, Maryland</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</u>  |   | 25a. REC'D BY REGISTRAR  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 11204 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14174

FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; not done before admission)<br>e. STATE <u>md</u> b. COUNTY <u>Montgomery</u>                   |  |   |  |
| b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>  |  |   |  | c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>  |  |   |  |
| c. LENGTH OF STAY IN <u>10 yrs</u>   |  |   |  | d. STREET ADDRESS<br><u>909 Kenbrook Dr</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>909 Kenbrook Dr</u>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Milton Aaron Brensky</u>   |  |   |  | 4. DATE OF DEATH<br><u>Dec 23 1961</u>   |  |   |  |
| 5. SEX<br><u>male</u>  |  | 6. COLOR OR RACE<br><u>white</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>5-5-1912</u>           |  |
| 9. AGE (In years last b. day)<br><u>49</u> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Edt. research Dir. Wash-Stan</u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>Pa</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |  |
| 13. FATHER'S NAME<br><u>Nath Isaacne Brensky</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Annice Thress</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |  |   |  | 16. SOCIAL SECURITY NO.<br><u>198-05-3524</u>  |  |   |  |
| 17. INFORMANT<br><u>Elaine Brensky (wife)</u>  |  |   |  | Address<br><u>Itan 2</u>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cornary occlusion</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u></u><br>(c) <u></u><br>DUE TO<br>(a), stating the underlying cause last. (c) <u></u>   |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Hearting of csa Feb 1960</u>   |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                      |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                         |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)          |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><u>Frank J. Broschalt</u>  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type)<br><u>FRANK J. Broschalt</u>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  |   |  | 22b. DATE THEREOF<br><u>DEC 24, 1961</u>   |  |   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>KING DAVID MTH. GARDEN</u>  |  |   |  | 22d. LOCATION (City, town, or country) (State)<br><u>FALLS CHURCH VA.</u>  |  |   |  |
| 23. FUNERAL DIRECTOR<br><u>Dougherty &amp; Sons</u>  |  |   |  | 24a. REC'D BY REGISTRAR<br><u>DEC 28 '61</u>   |  |   |  |
| ADDRESS<br><u>3501-14 ST. N.W.</u>   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Charles S. Hanna</u>  |  |   |  |



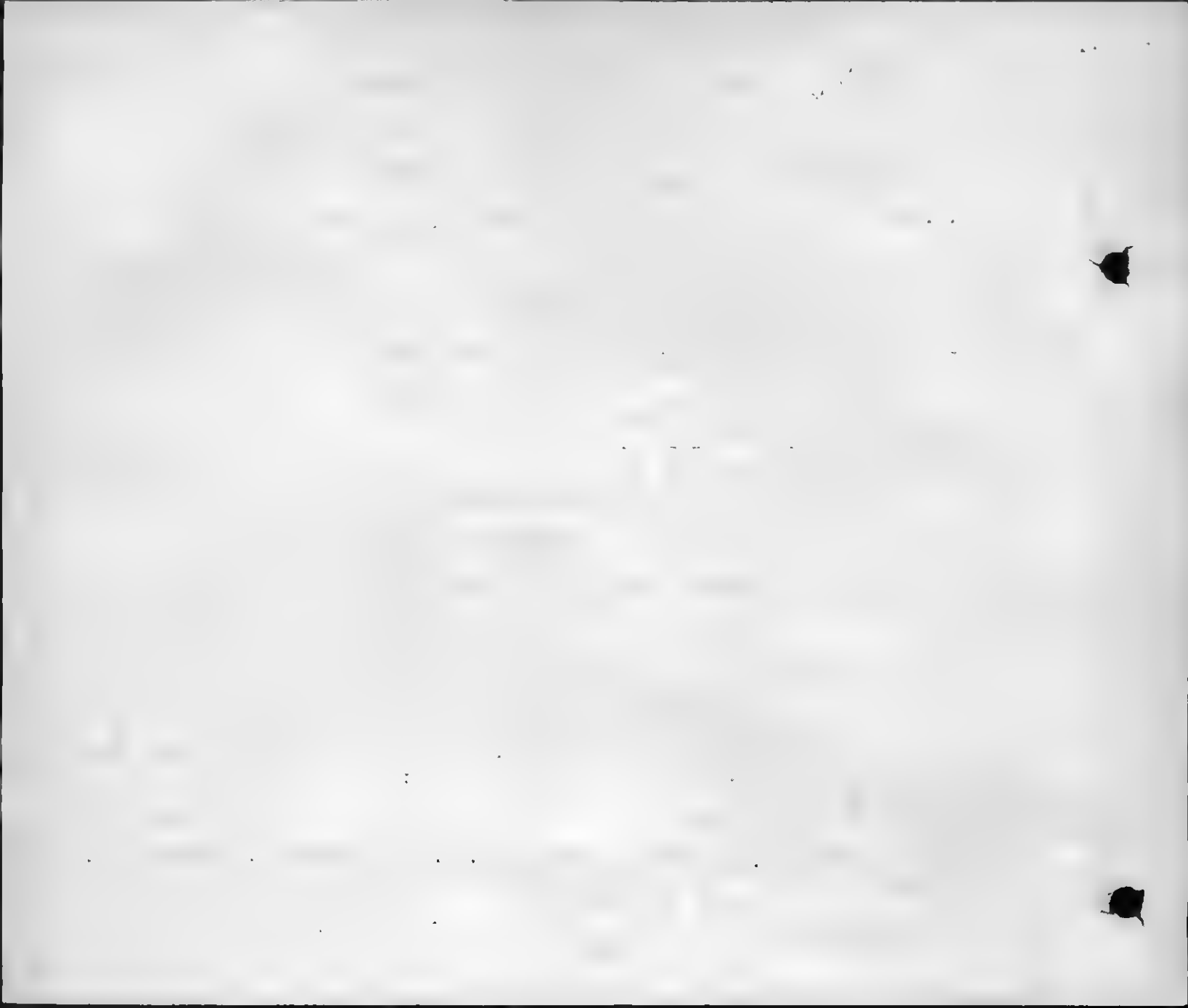


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7/61

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |  |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |  |  |
| 14205 Items 13 & 23b Film 6301 12/20/61 14175  |  |  |  |  |  |  |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u>  |  |  |  | b. COUNTY <u>H...</u>   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>   |  |  |  | c. LENGTH OF STAY IN IT <u>30 days</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. Naval Hospital</u>  |  |  |  | d. STREET ADDRESS <u>1905 Lincoln Drive</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |  |  |
| 3. NAME OF <u>BRECKENRIDGE</u><br>(Type or print) <u>Brenda</u>  |  |  |  | 4. DATE OF DEATH <u>December 20, 1961</u>  |  |  |  | Last <u>Pugh</u> Month <u>December</u> Day <u>20</u> Year <u>1961</u>                             |  |  |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>Negroid</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>October 12, 1952</u>                                       |  | 9. AGE (In years last birthday) <u>9</u> yrs.   |  | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>  </u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>                               |  |  |  |
| 13. FATHER'S NAME <u>Daniel Pugh</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Florine Brown</u>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>   |  |  |  | 16. SOCIAL SECURITY NO. <u>  </u>  |  |  |  | 17. INFORMANT <u>  </u> Address <u>  </u>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>POSSIBLE EMBOLIZATION</u>  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO (b) <u>SUBACUTE BACTERIAL ENDOCARDITIS</u>  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO (c) <u>MITRAL AND TRICUSPID REGURGITATION</u>   |  |  |  |  |  |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>  |  |  |  |  |  |  |  |   |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH <u>  </u>   |  |  |  |  |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>   |  |  |  |  |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>  </u>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>   |  | 20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>             |  | 19. WAS AUTOPSY REFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |  |  |  |
| 21. I certify that (X) (this hospital) attended the deceased from <u>Nov. 20, 1961</u> to <u>Dec. 20, 1961</u> that (X) (we) last saw the deceased alive on <u>Dec. 20, 1961</u> and that death occurred at <u>5:30 AM</u> from the causes and on the date stated above. |  |  |  |  |  |  |  |   |  |  |  |
| 22a. SIGNATURE <u>Bernard H. Feldman</u>   |  |  |  | M.D. <u>  </u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>           |  |  |  | 22b. DATE SIGNED <u>December 20, 1961</u>   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>BERNARD H. FELDMAN LT MC USN</u>   |  |  |  | 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>Dec. 24, 1961</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Mount Calvary</u>  |  | 23d. LOCATION (City, town or county) <u>Arnold, Maryland</u> (State) <u>  </u> |  |   |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Feldman</u>   |  |  |  | ADDRESS <u>Annapolis, Md.</u>  |  |  |  | 25a. REC'D BY REGISTRAR <u>  </u>   |  | 25b. REGISTRAR'S SIGNATURE <u>  </u>   |  |
| DATE <u>Dec 26 '61</u>   |  |  |  | DATE <u>DEC 26 '61</u>   |  |  |  |   |  |  |  |



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14208

14176

|  |                                  |   |                                    |  |  |   |   |
|--|----------------------------------|---|------------------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>   |                                  |   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/><br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silver Spring</u>   |                                  |   | c. LENGTH OF STAY IN 1b            |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Clinton</u> |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Marilea Nursing Home</u>  |                                  |   |                                    | d. STREET ADDRESS  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Nannie</u> Middle <u>E.</u> Last <u>Revell</u>   |                                  |   |                                    | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>26th</u> Year <u>1961</u>   |  |   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Unknown</u> |  | 9. AGE (In years last birthday)<br><u>89</u> yrs.  | IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u><br>IF UNDER 24 HRS. |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House wife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>Samuel Harris</u>  |                                  |   |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Minnie Jones</u>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                                  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)  |                                    | 17. INFORMANT<br><u>Mrs Brooks Matthews LaPlata, Md</u>  |  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><u>331X</u> DUE TO <u>Coronary Thrombosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u><br>(c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> |                                  |   |                                    |  |  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |                                    |  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-22-1961</u> to <u>12-25-1961</u> , that (I) (we) last saw the deceased alive on <u>12-22-1961</u> , and that death occurred <u>5:10 PM</u> from the causes and on the date stated above  |                                  |   |                                    |  |  |   |   |
| 22a. SIGNATURE<br><u>John S. Rogers M.D.</u>   |                                  |   |                                    | 22b. DATE SIGNED<br><u>12-25-61</u>  |  | 22c. PHYSICIAN'S NAME (Type)<br><u>John S. Rogers M.D.</u>  |   |
| 22d. ADDRESS<br><u>112 Shaw Avenue, Silver Spring, Md</u>  |                                  |   |                                    |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>12/28/1961</u>  |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St John's</u>   |  | 23d. LOCATION (City, town, or county) (State)<br><u>Clinton, Md</u>                                 |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Gobernally</u>  |                                  |   |                                    | 25a. REC'D BY REGISTRAR<br><u>Wash 3 Ltr</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Harris</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 11

14207

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda Md.</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>5th Bethesda</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>4532 FAIRFIELD DRIVE</u>   |   | 1 d STREET ADDRESS<br><u>4532 FAIRFIELD DRIVE</u>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Grace Truman Ridgeway</u>   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>December 13 1961</u>   |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>MARCH 16, 1891</u>                                      |
| 9. AGE (In years last birthday)<br><u>70</u> yrs.   |   | 10. IF UNDER 1 YEAR: Months Days Hours Min.<br>IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Auditor - Retired</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>U.S. Government</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Virginia</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>OTTO C. RIDGEWAY</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>SARAH BROWN</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO.<br><u>MISS EVELYN D. BEALL</u>  |  |
| 17. INFORMANT<br><u>Bethesda, Md.</u>   |   | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |   |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u><br><u>420.0</u> DUE TO   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 hours</u>  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |   | (b) <u>Acute Left Ventricular Heart Failure</u> <u>3 hours</u>  |  |
| (c) <u>Arteriosclerotic Heart Disease</u> <u>4 years</u>  |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Chronic Non-obstructive Emphysema, Chronic Cor Pulmonale</u>  |   |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>December 11, 1961</u> , to <u>Dec 13, 1961</u> , that I last saw the deceased alive on <u>December 13, 1961</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. |   |   |  |
| ADDRESS (Street, city or town, state)   |   | DATE SIGNED   |  |
| ACTUAL SIGNATURE <u>Clifton R. Pruner</u> M.D.  |   | <u>915 19th St. N.W. Wash. D.C. 12/13/61</u>  |  |
| PHYSICIAN'S NAME (Type) <u>Clifton R. Pruner, M.D.</u>  |   | <u>275 - 10th St. N.W. Wash. D.C.</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 22b. DATE THEREOF<br><u>DEC. 16, 1961</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>FREDERICK</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>WARREN COUNTY VIRGINIA</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>MADDOX FUNERAL HOME</u><br><u>2400 24th St. S.E.</u>   |   | 24a. REC'D BY REGISTRAR<br><u>FRONT ROYAL, VA.</u>  | 24b. REGISTRAR'S SIGNATURE<br><u>W. L. S. Thana</u>                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

## Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

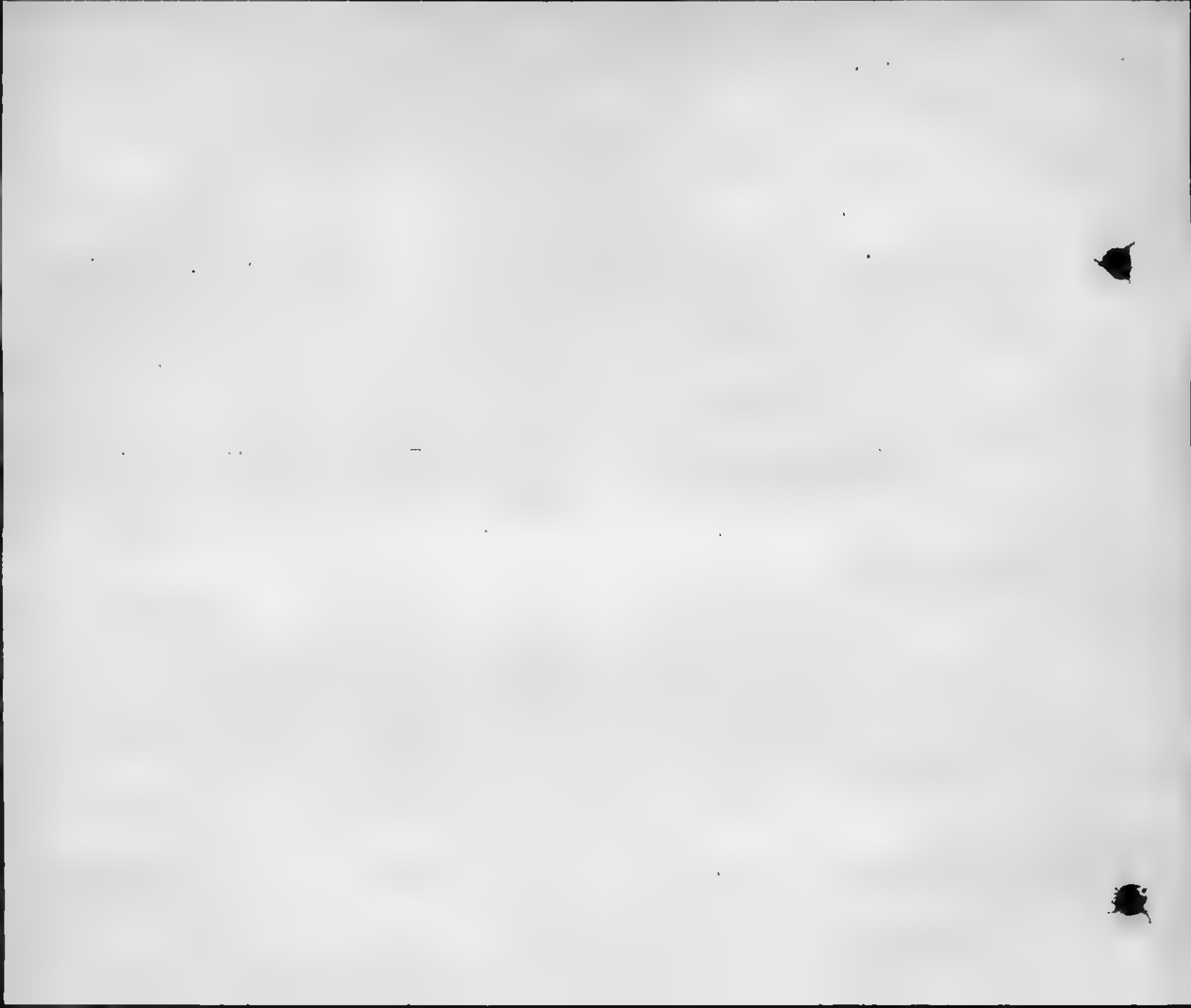
### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14208

11178

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  | c. LENGTH OF STAY IN 1b <u>25 mins</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>  |  | e. STREET ADDRESS <u>4730 Bradley Blvd</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>Martin</u>   |  | 4. DATE OF DEATH <u>Dec. 26. 1961</u>   |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <u>9/9/09</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>New York</u>   |  |
| 13. FATHER'S NAME <u>David</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Rosch</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>  |  | 16. SOCIAL SECURITY NO. <u>Ross</u>   |  |
| 17. INFORMANT <u>Harriet Hunt - 4904 River Rd., Beth Md. (friend)</u>   |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Insufficiency</u><br>(b) <u>Coronary Occlusion, left Circumflex Coronary Artery</u><br>(c) <u>Hemorrhage into Atherosclerotic Plaque</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)    |  |   |  |
| 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE <u>Frank J. Brochart</u> M.D.  |  | DATE SIGNED <u>12-26-61</u>   |  |
| EXAMINER'S NAME (Type) <u>Frank J. Brochart</u>   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>12-28-61</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>   |  | 22d. LOCATION (City, town, or country) (State) <u>Balto Md</u>  |  |
| 23. FUNERAL DIRECTOR <u>Jess Lewis Inc 2100 Eutaw Place</u>   |  | 24a. REC'D BY REGISTRAR <u>DEC 28 '61</u>   |  |
| 24b. REGISTRAR'S SIGNATURE <u>Jess Lewis</u>  |  |   |  |

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, page 1, 2, and 3, may be retained for 72 hours after death. The certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for 72 hours after death. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





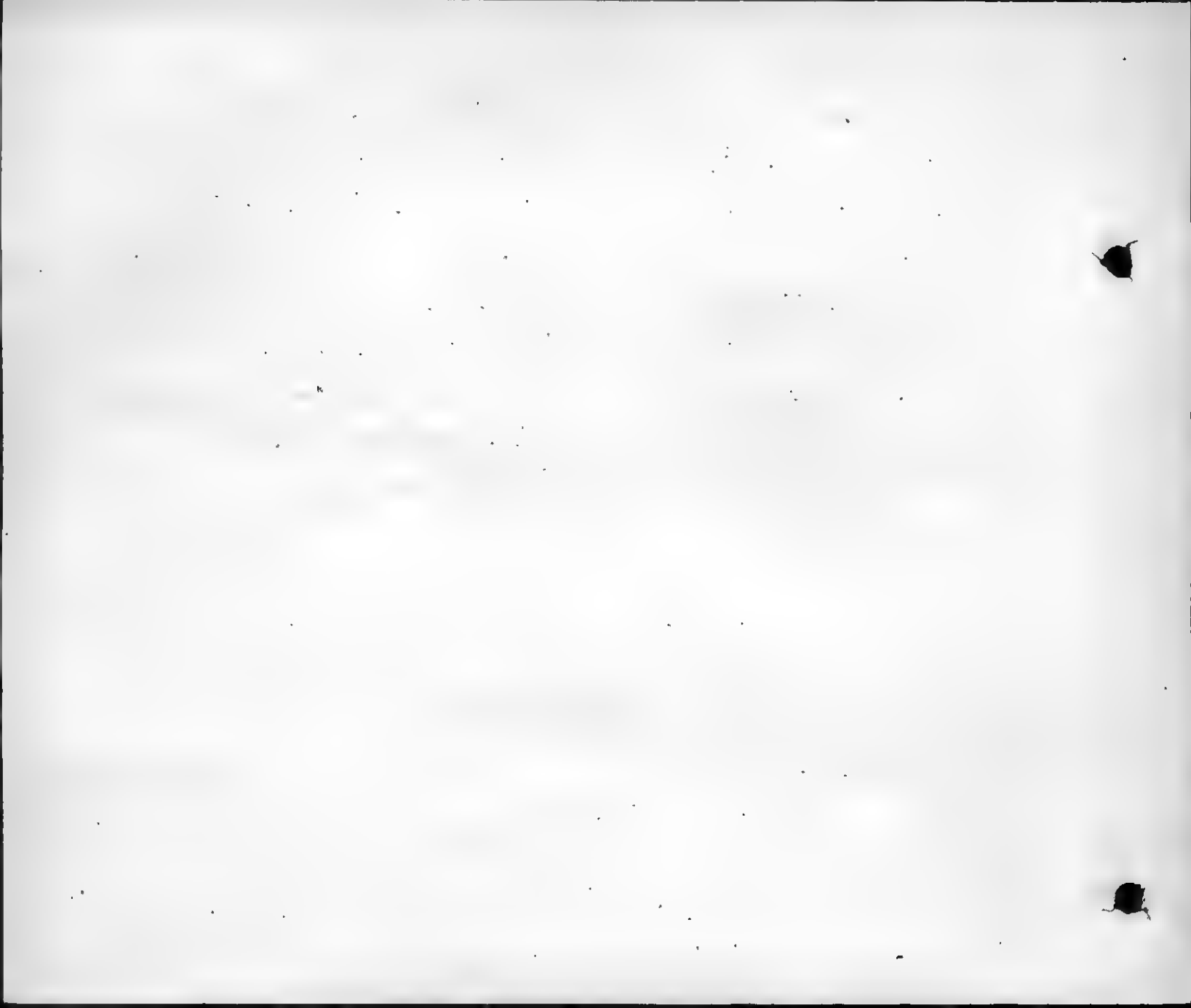
## CERTIFICATE OF DEATH

Reg. Dist. No. 14179

14209

|   |                                   |  |   |
|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |                                   | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>   |                                   | c. LENGTH OF STAY IN 1b <u>21 hrs.</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Hospital End Sanitarium</u>  |                                   | d. STREET ADDRESS <u>6006-Belle Court</u>  |   |
| 3. NAME OF DECEASED (Type or print) <u>Samuel</u> First Middle Last <u>Sabato</u>   |                                   | 4. DATE OF DEATH <u>12-21</u> Month Day Year <u>1961</u>   |   |
| 5. SEX <u>male</u>  | 6. COLOR OR RACE <u>white</u>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>October 17, 1899</u>                              |
| 9. AGE (In years last birthday) <u>62</u> yrs.  |                                   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waiter</u>   | 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>     |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |                                   | 13. FATHER'S NAME <u>Unknown</u>   |   |
| 14. MOTHER'S MAIDEN NAME <u>Unknown</u>   |                                   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |   |
| 16. SOCIAL SECURITY NO. <u>Informant</u>  |                                   | Address <u>above</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY THROMBOSIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u><br>(c) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> |                                   | INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSION, ARTERIAL</u>  |                                   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY: Month, Day, Year<br>Hour o. m. <u>19</u> p. m.   |                                   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>AUG. 1959</u> to <u>DEC. 21, 1961</u> , that I last saw the deceased alive on <u>DEC. 21, 1961</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.  |                                   |  |   |
| ACTUAL SIGNATURE <u>L.B. Snow</u> M.D.  |                                   | DATE SIGNED <u>12/21/61</u>  |   |
| PHYSICIAN'S NAME (Type) <u>L.B. SNOW</u>  |                                   | <u>7950 N.H. Ave. Langley Park Md.</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>12/23/61</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>   | 22d. LOCATION (City, town, or county) (State) <u>Colman Manor Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home, Inc.</u>   |                                   | 24a. REC'D BY REGISTRAR <u>Mt Rainier Md.</u>  | 24b. REGISTRAR'S SIGNATURE <u>C. E. Jones</u>                         |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND14210  
CERTIFICATE OF DEATH

14180

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12210</b><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CONGRESSIONAL MANOR</b>                  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>New Jersey</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRIDGEWATER, New Jersey</b><br>d. STREET ADDRESS <b>9218 1/2 WASHINGTON AVE</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <b>Katherine</b> First <b>St. Peter</b> Middle Last<br>4. DATE OF DEATH Month <b>12</b> Day <b>10</b> Year <b>1961</b>   |  | 5. SEX <b>F</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>March 6 1886</b> 9. AGE (In years last birthday) <b>75</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b> 11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>  |  | 13. FATHER'S NAME <b>PATRICK MADIGAN</b> 14. MOTHER'S MAIDEN NAME <b>HANORA SHANAHAN</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b> 16. SOCIAL SECURITY NO. <b>—</b> 17. INFORMANT <b>Virginia St. Peter</b> Address <b>28 SEC Hgt 2nd GSA FT. MEADE MD</b>  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br><b>IX</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Coronary Artery Disease, Chronic pyelonephritis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)           |  | 21. I certify that (I) (this hospital) attended the deceased from <b>13 Oct 1958</b> to <b>10 Dec 1961</b> , that (I) (we) last saw the deceased alive on <b>10 Oct 1961</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.   |  |
| 22a. SIGNATURE <b>David A. Skel</b> M.D. 22b. DATE SIGNED <b>10 Dec 1961</b> 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS   |  | 23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>12-14-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>MARY REST CEMETERY</b> 23d. LOCATION (City, town, or county) (State) <b>DARLINGTON NEW JERSEY</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Deaf Funeral Home</b> ADDRESS <b>4812 Lakewood</b> 25a. REC'D BY REGISTRAR <b>DATE DEC 13 61</b> 25b. REGISTRAR'S SIGNATURE <b>C. J. H. H.</b>   |  |   |  |

11-11-11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

YR A15 (4)  
15M 9/60

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(1)

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

14211 14181

1. PLACE OF DEATH  
a. COUNTY MONTGOMERY MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON  
c. LENGTH OF STAY IN b 9 days  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WHEATON NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE MARYLAND COUNTY PRINCE GEORGES  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARLINGTON  
d. STREET ADDRESS 2347 South Nash St

3. NAME OF DECEASED (Type or print) PRENTISS First DIXON Middle SALE JR Last  
4. DATE OF DEATH 12 Month 27 Day 19 Year 61

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH MARCH 15, 1892 9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M. n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED 10b. KIND OF BUSINESS OR INDUSTRY KNOXVILLE, TENN. 11. BIRTHPLACE County & State, or foreign country USA 12. CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME PRENTISS D. SALE SR 14. MOTHER'S MAIDEN NAME CAROLYN HESSEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. ? 17. INFORMANT Home Records

18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))  
PART DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) CEREBRAL Hemorrhage  
DUE TO hyper Tension  
Conditions, if any, which gave rise to immediate cause (b) hyper Tension  
DUE TO hyper Tension  
cause last. (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

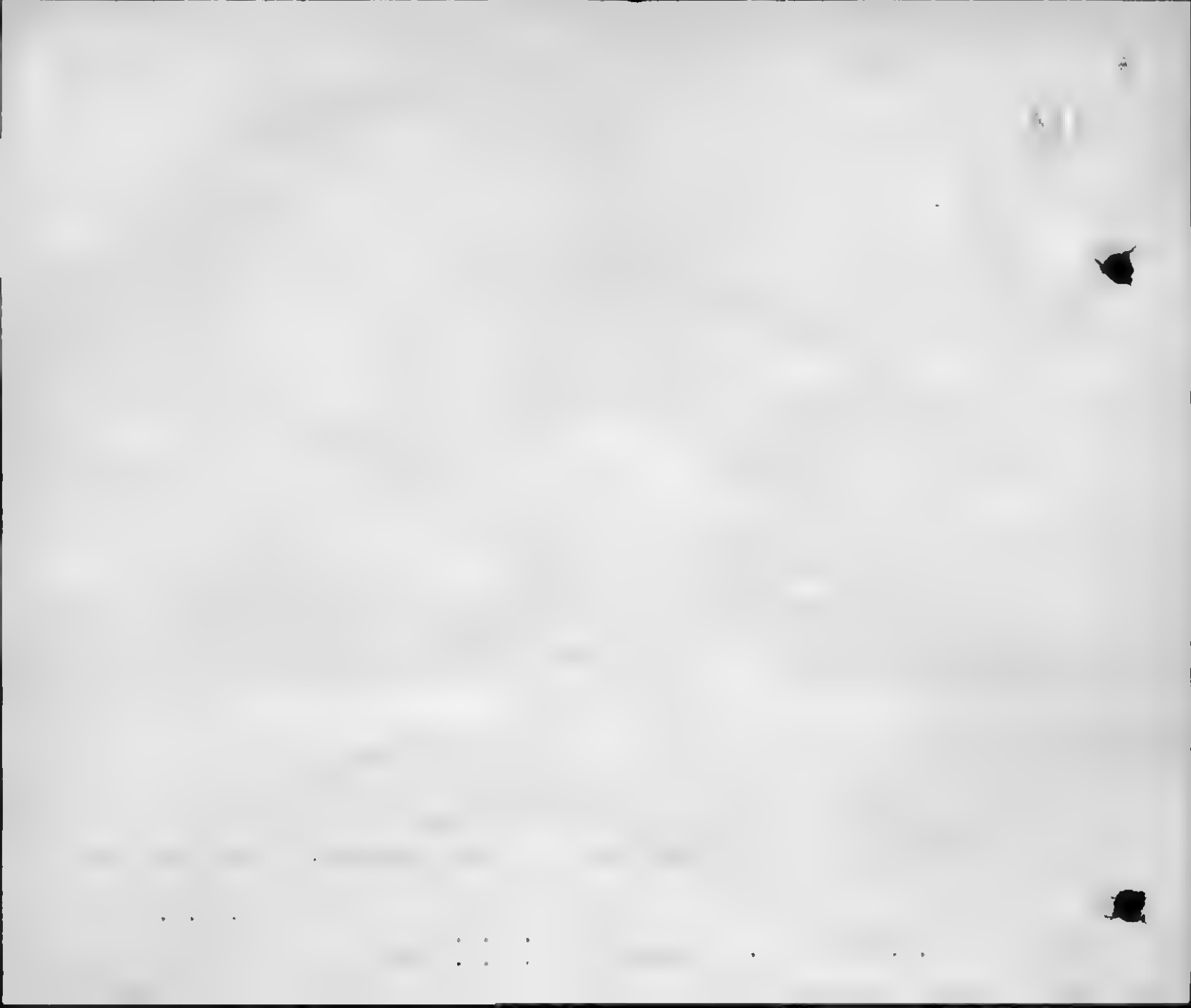
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 19, 1961, to Dec. 27, 1961 that (I) (we) last saw the deceased alive on Dec. 27, 1961, and that death occurred at 11:30 M, from the causes and on the date stated above.

22a. SIGNATURE Belden R. Reap M.D. 22b. DATE SIGNED Dec. 27, 1961  
22c. PHYSICIAN'S NAME (Type) BELDEN R. REAP, M.D. 22d. ADDRESS 11502 GRANOVIEW AVE, WHEATON, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) burial 23b. DATE THEREOF 12/30/61 23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery 23d. LOCATION (City, town or county) (State) Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 25a. REC'D BY REGISTRAR 2901 14th St. N.W. 25b. REGISTRAR'S SIGNATURE Washington 9, D.C. DATE JAN 2 '62



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove sections 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14212  
CERTIFICATE OF DEATH  
14182

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6304 TONE DR.</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u><br>d. STREET ADDRESS <u>6304 TONE DR.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <u>HYMAN</u> First <u>SALZBERG</u> Middle <u>SALZBERG</u> Last<br>4. DATE OF DEATH <u>12</u> <u>10</u> <u>19</u> <u>61</u><br>5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>APR 15 1893</u> 9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M.n.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>TRUCKING</u><br>11. BIRTHPLACE (County & State, or foreign country) <u>POLAND</u><br>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |  |  |
| 13. FATHER'S NAME <u>ABRAHAM SALZBERG</u><br>14. MOTHER'S MAIDEN NAME <u>YETTA</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u><br>16. SOCIAL SECURITY NO. <u>060-20-4414</u><br>17. INFORMANT <u>SAMUEL SALZBERG</u> Address <u>8409 SPENNER ST. CHEVY CHASE MD.</u>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEPATIC METASTASES</u><br><u>153.8</u> DUE TO<br>Conditions, if any which gave rise to immediate cause (b) <u>CARCINOMA OF THE COLON</u><br>(c), stating the underlying cause last. DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>9 mos.</u><br><u>17 mos.</u> |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)     |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>NOV 7, 1961</u> to <u>DEC 10, 1961</u> , that (I) (we) last saw the deceased alive on <u>12/10, 1961</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.<br>22a. SIGNATURE <u>J.H. Tuohy</u><br>22c. PHYSICIAN'S NAME (Type) <u>J.H. Tuohy, M.D.</u><br>22d. ADDRESS <u>7720 WISCONSIN AVE BETHESDA 14, MD.</u><br>22b. DATE SIGNED <u>12/10/61</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u><br>23b. DATE THEREOF <u>12-10-61</u><br>23c. NAME OF CEMETERY OR CREMATORY <u>WILM. HERMON</u><br>23d. LOCATION (City, town or county) (State) <u>LONG ISLAND, N.Y.</u>   |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>GOLDBERG FUNERAL HOME</u> ADDRESS <u>4217 9TH ST. NW</u><br>25a. REC'D BY REGISTRAR <u>DEC 13 '61</u><br>25b. REGISTRAR'S SIGNATURE <u>William E. Kraus</u>   |  |  |  |



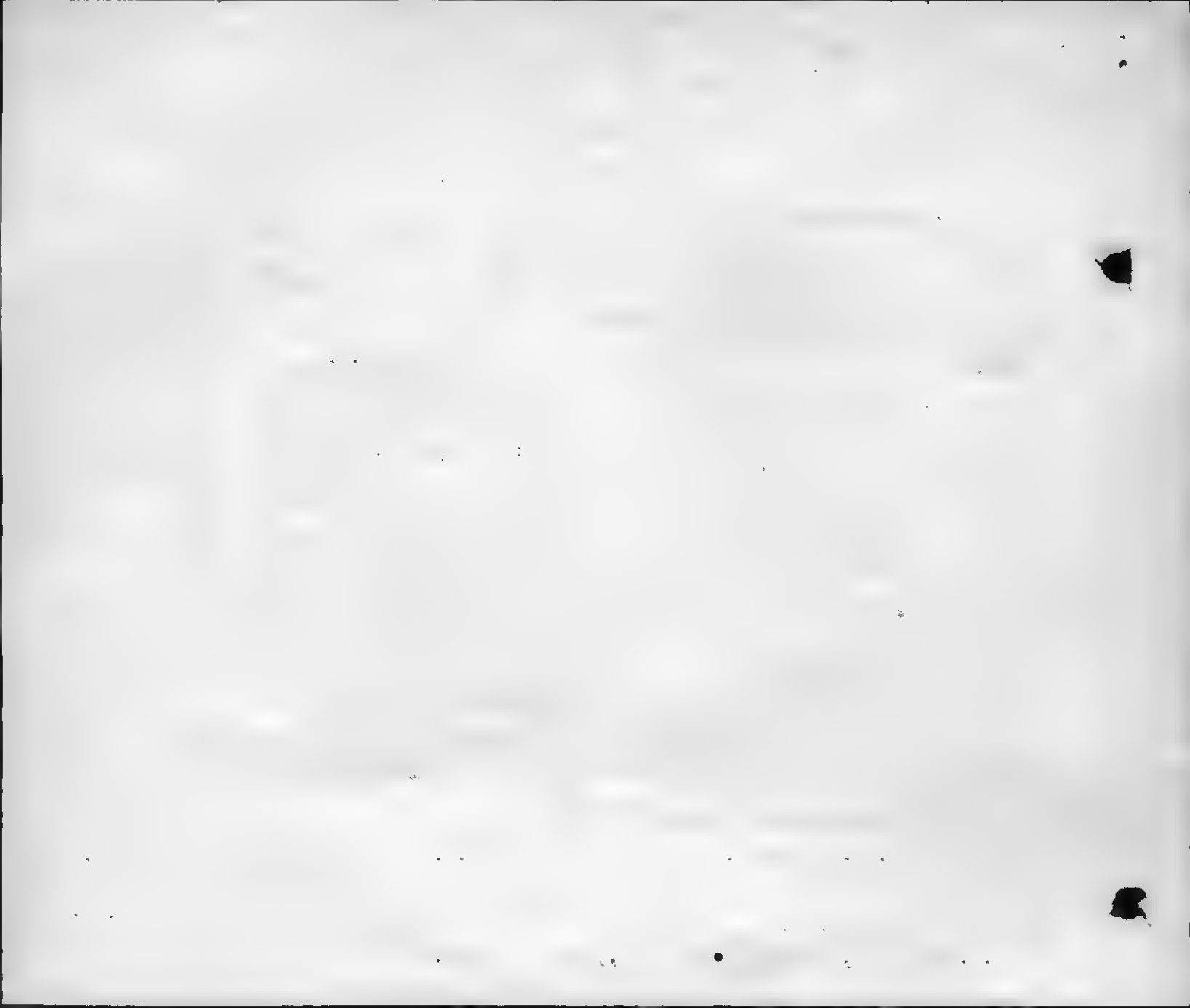


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. The law requires that the death certificate be executed within 24 hours after the death. The law requires that the death certificate be executed within 24 hours after the death.

VR AIS (4)  
15M 7/61

MEDICAL CERTIFICATION

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 14213 CERTIFICATE OF DEATH 14183  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Item 23b, Film 6504, 12/62, iwk   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u><br>c. LENGTH OF STAY IN ID <u>42 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>California</u><br>b. COUNTY <u>La Jolla</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Jolla</u><br>d. STREET ADDRESS <u>PO Box 447</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Charles</u> Middle <u>Roosa</u> Last <u>Sanderson</u>   |  |  |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>22</u> Year <u>1961</u>  |  |  |  | 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-25-32</u> 9. AGE (In years last birthday) <u>179</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Military</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME <u>John W. Sanderson</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Alice Oulahan</u>   |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) <u>Yes</u>  |  |  |  | 16. SOCIAL SECURITY NO. <u>-----</u> 17. INFORMANT <u>WIFE: Florence J. Sanderson, same as #2</u> Address <u>-----</u>                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PERIPHERAL VASCULAR COLLAPSE</u><br>DUE TO (b) <u>Thrombosis in distribution left middle cerebral artery</u><br>DUE TO (c) <u>ARTERIOSCLEROSIS, GENERALIZED</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).   |  |  |  |   |  |  |  |  |  |  |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  |  |  |  |  |  |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |  |  |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Hour a.m. <u>19</u> p.m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21. I certify that <u>10</u> (this hospital) attended the deceased from <u>2 November, 1961</u> to <u>22 December, 1961</u> , that <u>18</u> (we) last saw the deceased alive on <u>22 December 1961</u> , and that death occurred at <u>18:56 PM</u> from the causes and on the date stated above.   |  |  |  |   |  |  |  |  |  |  |  | 22a. SIGNATURE <u>John R. W. Rmolts MD</u> M.D. 22b. DATE SIGNED <u>Dec 23, 1961</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>J. R. W. RMOLTS, LT MC USN</u>  |  |  |  | 22d. ADDRESS <u>U.S. Naval Hospital, Bethesda, Md.</u>  |  |  |  | 22e. REC'D BY REGISTRAR <u>DEC 27 '61</u>  |  |  |  | 22f. REGISTRAR'S SIGNATURE <u>Arthur L. Kram</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |  |  | 23b. DATE THEREOF <u>Dec. 26, 1961</u>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>   |  |  |  | 23d. LOCATION (City, town or county) (State) <u>Arlington, Vir.</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert M. Rasmussen</u> ADDRESS <u>1111 Wisconsin Ave., Bethesda, Md.</u>   |  |  |  |   |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR <u>DEC 27 '61</u>  |  |  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kram</u>   |  |  |  |  |  |  |  |  |  |  |  |





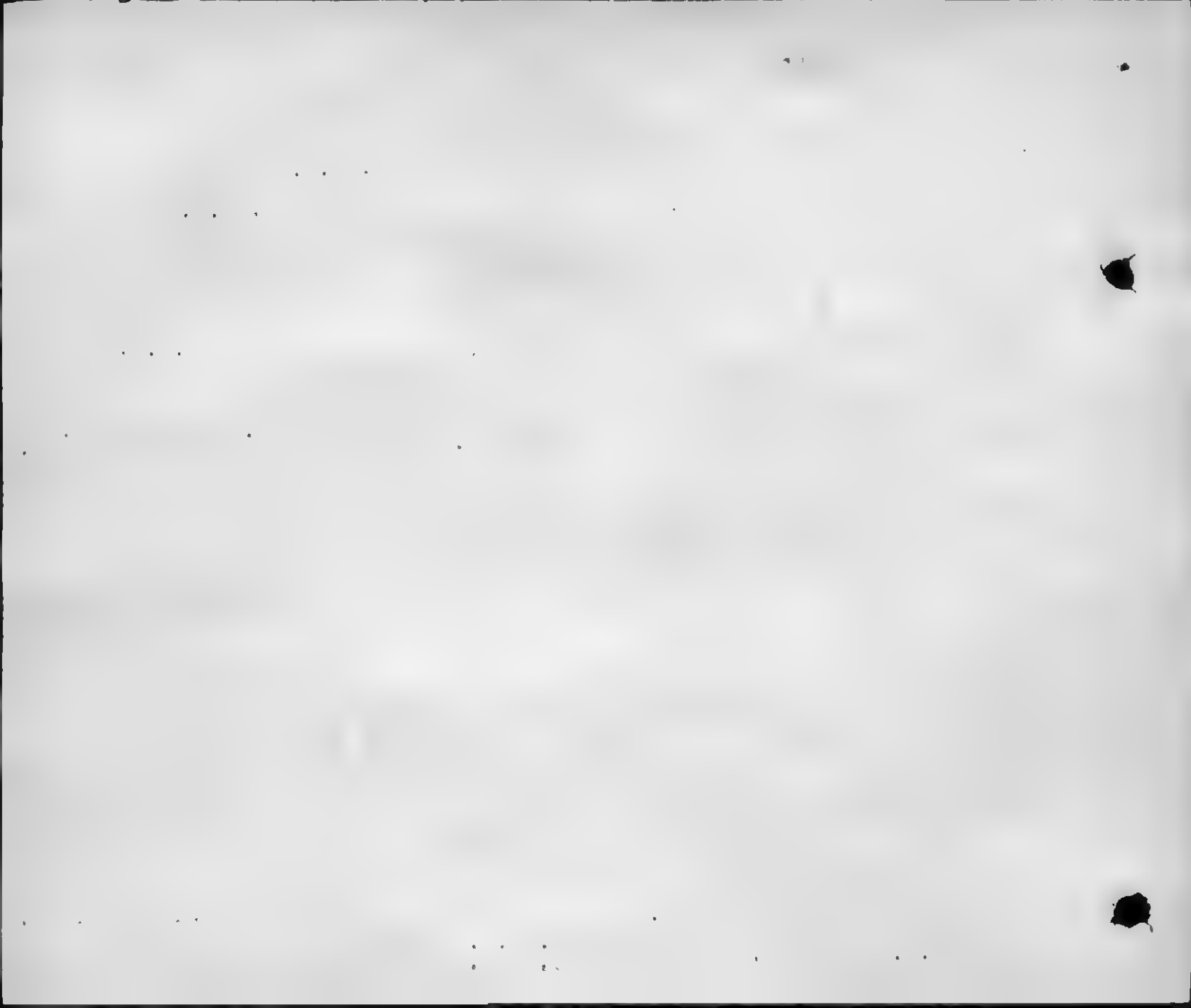


HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                           |  |  |  |  |  |  |  |  |  |
|--|--|---------------------------|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                           |  |  |  |  |  |  |  |  |  |
| 14215 CERTIFICATE OF DEATH 14485   |  |                           |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |                           |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE _____ b. COUNTY _____              |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>   |  |                           |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>                             |  |  |  |  |  |
| c. LENGTH OF STAY IN 1b _____  |  |                           |  |  |  | d. STREET ADDRESS <u>2737 Devonshire Pl. N.W.</u>  |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Correll Hall Sanitarium</u>  |  |                           |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Wilson</u> First <u>Satterfield</u> Middle <u>Satterfield</u> Last  |  |                           |  |  |  | 4. DATE OF DEATH <u>Dec. 28</u> 19 <u>61</u> Month Day Year  |  |  |  |  |  |
| 5. SEX <u>M</u>  |  | 6. COLOR OR RACE <u>W</u> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>12/25/08</u>   |  | 9. AGE (In years last birthday) <u>53</u> yrs.   |  | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.                        |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Piano Tuner</u>   |  |                           |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>                                 |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                     |  |
| 13. FATHER'S NAME <u>Lawrence Satterfield</u>  |  |                           |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Kathryn Wilson</u>   |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |  |                           |  |  |  | 16. SOCIAL SECURITY NO. <u>?</u>   |  | 17. INFORMANT <u>Helen S. Steeds</u> Address <u>505 S. Genesee Ave. Los Angeles 36, Calif.</u> |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                           |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>   |  |                           |  |  |  |  |  |  |  |  |  |
| DUE TO (b) <u>Pyelonephritis</u>   |  |                           |  |  |  |  |  |  |  |  |  |
| DUE TO (c) <u>Generalized arteriosclerosis</u>   |  |                           |  |  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old cerebral vascular episode</u>   |  |                           |  |  |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                           |  |  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)   |  |                           |  |  |  |  |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>   |  |                           |  |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>None</u>  |  |                           |  |  |  |  |  |  |  |  |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |                           |  |  |  |  |  |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |                           |  |  |  |  |  |  |  |  |  |
| 20f. (City or town) (County) (State)   |  |                           |  |  |  |  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/26</u> , 19 <u>61</u> , to <u>12/28</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/28</u> , 19 <u>61</u> , and that death occurred at <u>6:30</u> P.M., from the causes and on the date stated above. |  |                           |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE <u>John B. Umhan</u>  |  |                           |  |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED <u>12/28/61</u>   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>John B. Umhan</u>  |  |                           |  |  |  | 22d. ADDRESS <u>8805 Conn. Ave Ch. Co. Md.</u>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>   |  |                           |  |  |  | 23b. DATE THEREOF <u>12/29/61</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>                                |  | 23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md.</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>   |  |                           |  |  |  | ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>   |  | 25a. REC'D BY REGISTRAR <u>JAN 2 '62</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>                              |  |



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14216

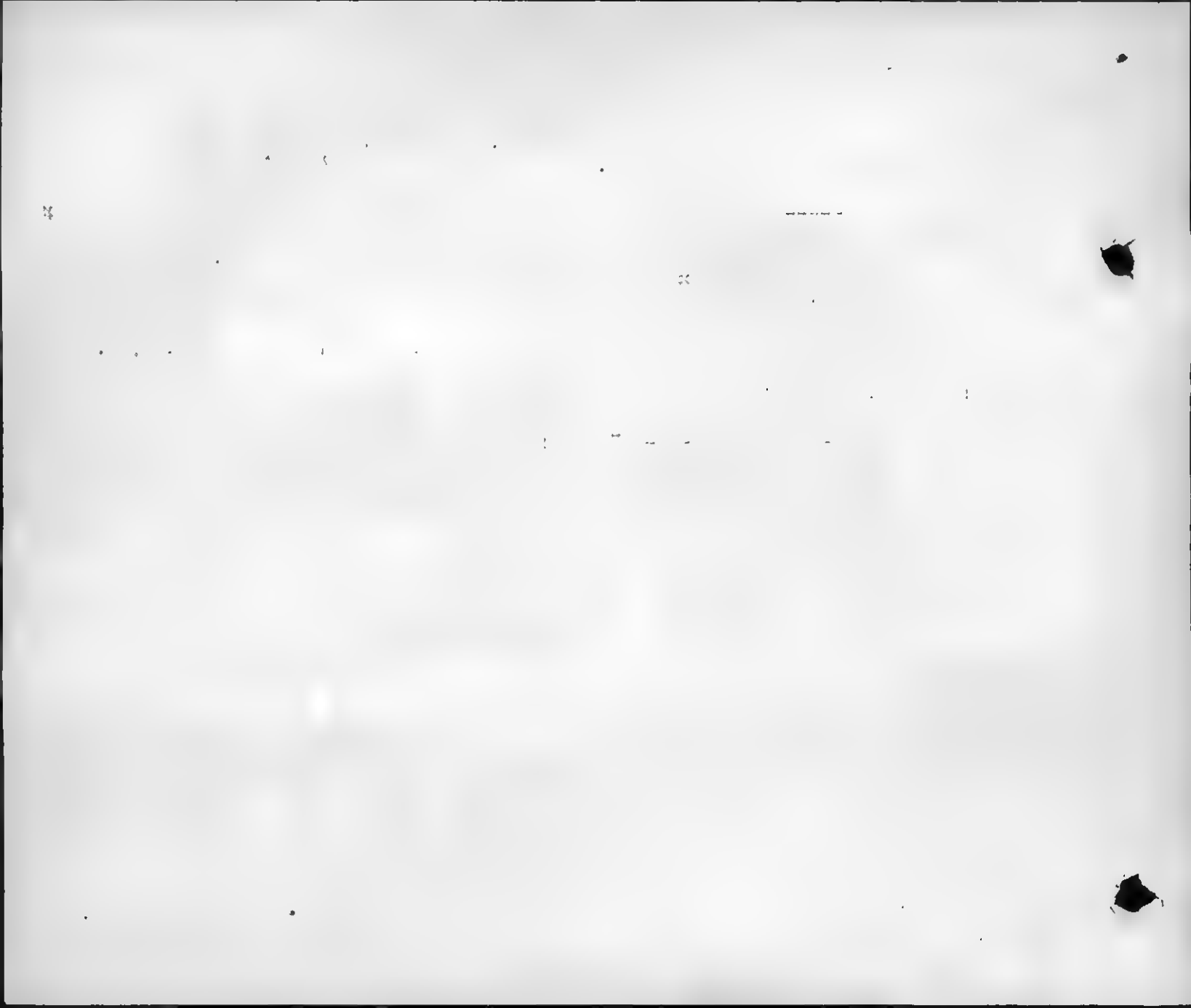
14186

Items 8, 9 & 14 Film 8-06 2/1/62 1wk

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MARYLAND</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>...</b>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SILVER SPRING</b>  |   | c. LENGTH OF STAY IN 1b<br><b>10 YRS.</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |   | d. STREET ADDRESS<br><b>9004 Sudbury Road</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>FREDERICK</b> Middle <b>R</b> Last <b>SAUNDERS</b>  |   | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>7</b> Year <b>1961</b>   |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 18, 1886</b><br><b>JULY 4, 1886</b>               |
| 9. AGE (In years last birthday)<br><b>75 yrs.</b>   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  | 11. BIRTHPLACE (State or foreign country)<br><b>NORFOLK, VIRGINIA</b>         |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   | 13. FATHER'S NAME<br><b>WILLIAM T. SAUNDERS</b>   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>ROSELLE WINNINGER Winingder</b>  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |   |
| 16. SOCIAL SECURITY NO.<br><b>224-26-1139</b>   |   | 17. INFORMANT<br><b>MISS EDITH SAUNDERS, SAME AS 2D, DAUGHTER</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma left upper lung</b><br>165X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>18 months</b>                          |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1948</b> to <b>Dec 7, 1961</b> that (I) last saw the deceased alive on <b>Dec 7, 1961</b> , and that death occurred at <b>10</b> M, from the causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><b>Saul Holtzman</b>  |   | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Saul Holtzman</b>  |   | 22d. ADDRESS<br><b>1800 E 4th St NW Wash. D.C.</b>  |   |
| 23a. BURIAL, CREMATION OR REMOVAL (Specify)<br><b>CREMATION</b>   | 23b. DATE THEREOF<br><b>12/8/61</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CREMATORY</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>BLADENSBURG, MARYLAND</b> |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph Bawlers Sons, 1752 Piquette</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 11</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>...</b>  |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                  |  |   |  |  |  |   |  |   |  |
|---|--|----------------------------------|--|---|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                  |  |   |  |  |  |   |  |   |  |
| CERTIFICATE OF DEATH  |  |                                  |  |   |  |  |  |   |  |   |  |
| 14217   |  |                                  |  |   |  |  |  |   |  |   |  |
| 14187   |  |                                  |  |   |  |  |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)<br>a. STATE <b>Md</b> b. COUNTY <b>Montgomery</b>                     |  |  |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  |                                  |  | c. LENGTH OF STAY IN 1b<br><b>11 days</b>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Suburban Hospital</b>  |  |                                  |  | d. STREET ADDRESS<br><b>8001 Bradley Blvd.</b>  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Thomas R. Scanlan</b>  |  |                                  |  | 4. DATE OF DEATH<br><b>12/27/1961</b>   |  |  |  | 5. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.<br><b>62 yrs.</b> Months Days Hours Min.   |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Jan. 16, 1899</b> |  | 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.<br><b>62 yrs.</b> Months Days Hours Min.   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Industrial Engineer</b>   |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Indx Engineer</b>   |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Pa.</b>   |  |   |  |
| 13. FATHER'S NAME<br><b>Arthur Andrew L.</b>  |  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Harriett Lingo</b>   |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>   |  |   |  |
| 16. SOCIAL SECURITY NO.<br><b>579-03-1601</b>   |  |                                  |  | 17. INFORMANT<br><b>Dorothy - wife</b>  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas</b><br>DUE TO <b>7X</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>7X</b><br>DUE TO <b>7X</b><br>cause last. (c) <b>7X</b> |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Phlebitis</b>   |  |                                  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><b>10:30 P</b>   |  |  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |  |                                  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>6450 Wisconsin Ave, Bethesda, Md.</b>  |  |   |  |
| 20f. (City or town)<br><b>Bethesda</b>  |  |                                  |  | 20g. (County)<br><b>Montgomery</b>  |  |  |  | 20h. (State)<br><b>Md</b>   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12/11/1961</b> to <b>12/27/1961</b> , that (I) (we) last saw the deceased alive on <b>12/27/61</b> , and that death occurred at <b>10:30 P</b> , from the causes and on the date stated above. |  |                                  |  |   |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Dr Joseph Kenrick</b>  |  |                                  |  | 22b. DATE SIGNED<br><b>12/28/61</b>   |  |  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Dr JOSEPH KENRICK</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                                  |  | 23b. DATE THEREOF<br><b>1/2/62</b>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>  |  |   |  |
| 23d. LOCATION (City, town or county)<br><b>Rockville, Maryland</b>  |  |                                  |  | 23e. REC'D BY REGISTRAR<br><b>JAN 2 '62</b>   |  |  |  | 23f. REGISTRAR'S SIGNATURE<br><b>William L. Hanna</b>   |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>   |  |                                  |  |   |  |  |  |   |  |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health. In any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14218

14188

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN <u>two weeks</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>1701 Pricilla Drive</u> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Louis</u> Middle <u>Brooks</u> Last <u>Schneider</u>   |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>17</u> Year <u>19 61</u>   |  |
| 5. SEX <u>Male</u><br>6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| 8. DATE OF BIRTH <u>October 25 1883</u><br>9. AGE (in years last birthday) <u>78</u> yrs.  |  | 10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>19</u> Hours <u>61</u>   |  |
| 11. BIRTH-PLACE (County & State, or foreign country) <u>Washington D.C.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>Louis H. Schneider</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Adele Brooks</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>None</u>   |  |
| 17. INFORMANT <u>Flourney C. Schneider</u>   |  | 18. ADDRESS <u>1353 11th Street, N.W. Washington D.C.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>THROMBOSIS L. MIDDLE CEREBRAL ARTERY</u><br>410X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>CONGESTIVE HEART FAILURE</u><br>DUE TO<br>(c) <u>MITRAL INSUFFICIENCY</u> |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>DIABETES MELLITUS</u>  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-17-1961</u> to <u>12-17-1961</u> , that (I) (we) last saw the deceased alive on <u>12-17-1961</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE <u>L. B. Snow</u>   |  | 22b. DATE SIGNED <u>12/17/61</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>LEE B. SNOW</u>  |  | 22d. ADDRESS <u>7950 NEW HAMPSHIRE AVE., LANGLEY PARK, MD.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>12/20/61</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Memorial Cemetery</u>  |  | 23d. LOCATION (City, town or county) (State) <u>Arlington New Jersey</u>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>   |  | 25. REC'D BY REGISTRAR <u>DEC 22 '61</u>  |  |
| 25a. ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Warner E. Humphrey</u>  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

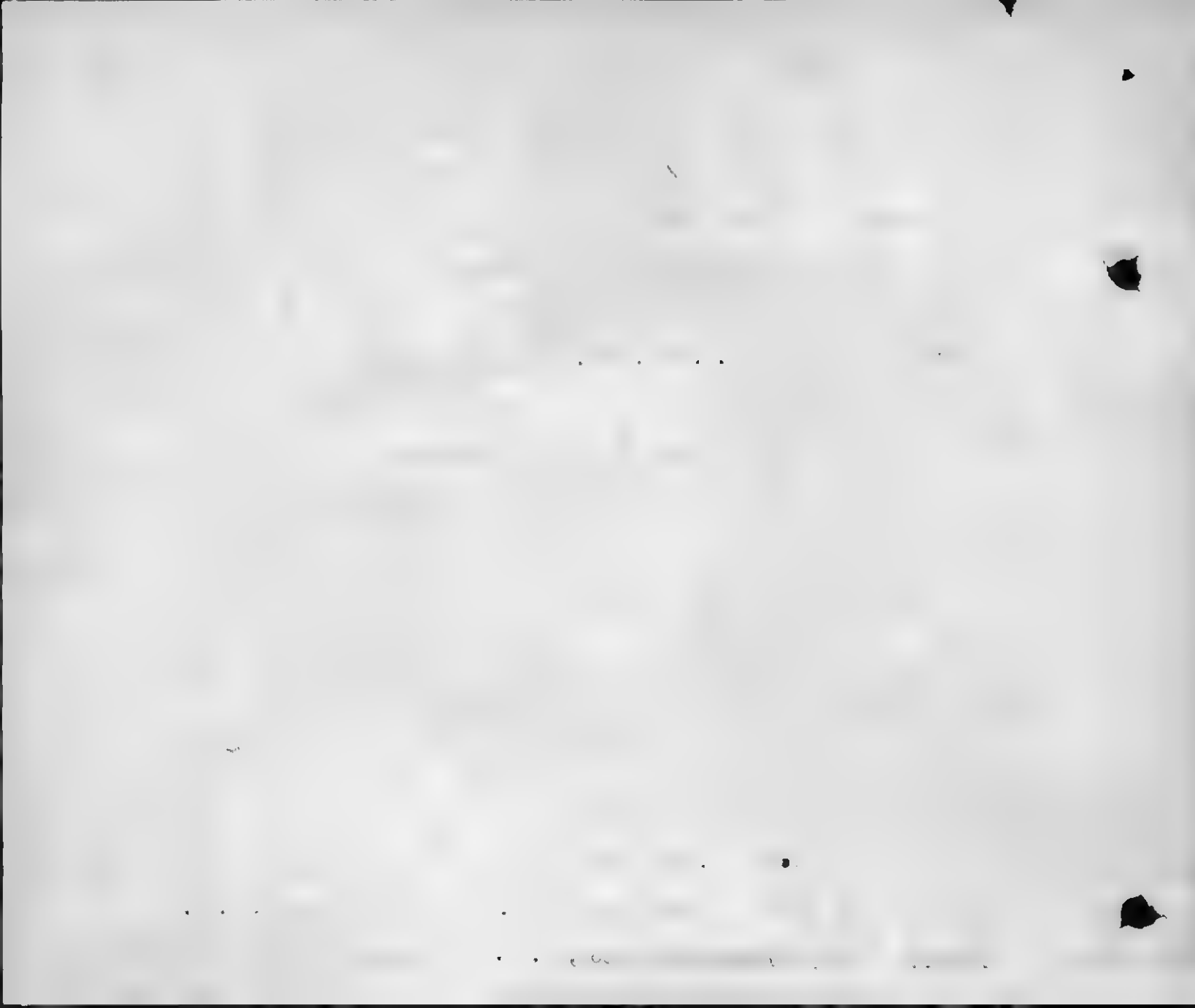
## CERTIFICATE OF DEATH

14219

14189

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY in lb <u>24 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Hospital</u>  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>D.C.</u> b. COUNTY _____<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u><br>d. STREET ADDRESS <u>2511 Lee St. N.W.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Leona Elizabeth Schoyer</u>  |  | <b>4. DATE OF DEATH</b><br>Month <u>12</u> Day <u>24</u> Year <u>1961</u> |  | <b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u>  |  |  |  |
| <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><u>9-7-1891</u>                                |  | <b>9. AGE</b> (In years last birthday) <u>70</u> yrs.<br><b>IF UNDER 1 YEAR</b> Months _____ Days _____<br><b>IF UNDER 24 HRS.</b> Hours _____ Min. _____  |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Clerk</u>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>U.S. Govt. Ret.</u>        |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Washington DC</u>   |  |  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.</u>  |  | <b>13. FATHER'S NAME</b><br><u>Louis Schoyer</u>                          |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Leona Beavers</u>  |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Unknown</u>  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>none</u>                             |  | <b>17. INFORMANT</b><br><u>Hospital Record</u>   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of the Ovary with metastatic</u><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>  |  |   |  |  |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner)<br><b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of Item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u><br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____ |  |   |  |  |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12/13</u> , 19 <u>61</u> , to <u>12/24</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> , 19 <u>61</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.  |  |   |  |  |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Michael R. Dobridge, M.D.</u>   |  |   |  | <b>22b. DATE SIGNED</b><br><u>12/24/61</u>   |  |  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Michael R. Dobridge</u>   |  |   |  | <b>22d. ADDRESS</b><br><u>10620 GEORGIA AVE SILVER SPRING MD</u>   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   |  | <b>23b. DATE THEREOF</b><br><u>12/27/61</u>                               |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Rock Creek Cemt.</u>   |  |  |  |
| <b>23d. LOCATION</b> (City, town or county)<br><u>Washington, D. C.</u>   |  | <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Joseph F. BIRCH'S SONS</u>  |  |  |  |  |  |
| <b>25a. REC'D BY REGISTRAR</b><br><u>DEC 27 '61</u>   |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>William E. Kenna</u>              |  |  |  |  |  |

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER THE DEATH. PAGE 4 MAY BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR. AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE DETACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. THEN PLEASE REMOVE CARBON PAPERS. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPT. OF HEALTH PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT, WITHIN 72 HOURS AFTER DEATH.



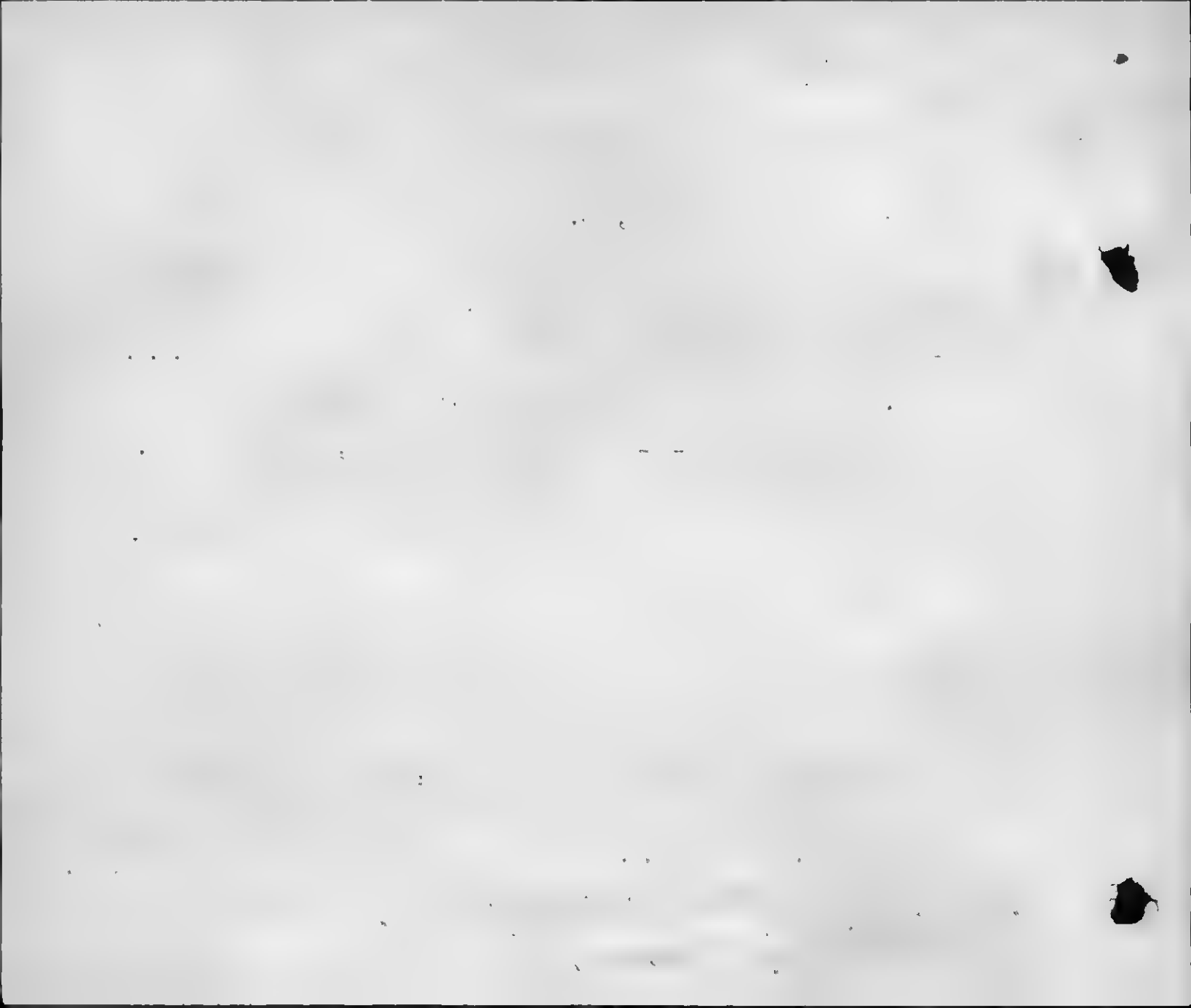
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14220

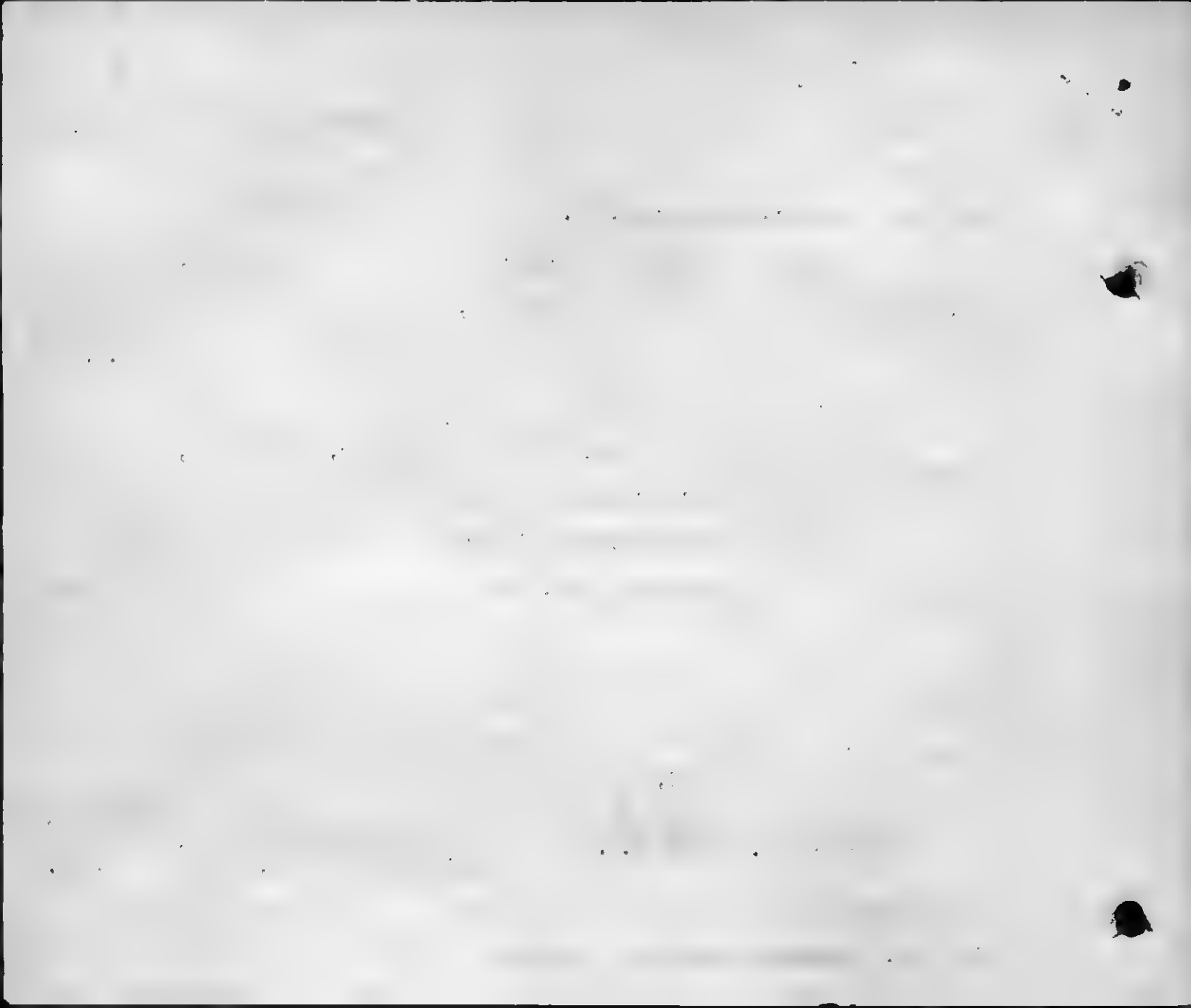
14190

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Res. date before admission)<br>a. STATE<br><b>Maryland</b>                                     |  | b. COUNTY<br><b>Prince Georges</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  | c. LENGTH OF STAY IN 1b<br><b>3 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>West Hyattsville</b>  |  | 1655-<br>d. STREET ADDRESS<br><b>1610 Erskine Street</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>The Clinical Center, Bethesda 14, Md.</b>  |  | 3. NAME OF DECEASED<br>(Type or print)<br><b>Joan Dawn Schuster</b>   |  | 4. DATE OF DEATH<br><b>December 30 1961</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>July 17, 1939</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk-Typist</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Government Agency</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>New Jersey</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Francis X. Schuster</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Uzonyi</b>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                    |  | 16. SOCIAL SECURITY NO.<br><b>1579-52-3420</b>  |  |
| 17. INFORMANT<br><b>The Clinical Center, Bethesda 14, Md.</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>456x</b> IMMEDIATE CAUSE (a) <b>Congestive Failure and Acute Pulmonary Edema</b><br>DUE TO (b) <b>Right lower lobe pneumonia and bleeding from GI tract. 4 days</b><br>DUE TO (c) <b>Disseminated lupus Erythematosus</b><br>5 years<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>CONTRIBUTING TO DEATH</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  |
| 20f. (City or town)   |  | (County)  |  | (State)  |  |   |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 27, 1961</b> to <b>December 30, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>December 30, 1961</b> , and that death occurred <b>8:00 PM</b> , from the causes and on the date stated above. |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><b>Mark W. Bitensky</b>   |  | 22b. DATE<br><b>December 30, 1961</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Mark W. Bitensky, M.D.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL, OR DISPOSITION<br><b>BURIAL</b>  |  | 23b. DATE THEREOF<br><b>JAN 3 1962</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON NATL CEM.</b>   |  |   |  |
| 23d. LOCATION (City, town or county)<br><b>ARLINGTON, VA.</b>   |  | 23e. REC'D BY REGISTRAR<br><b>254 Carroll St. NW</b>  |  | 23f. REGISTRAR'S SIGNATURE<br><b>Chas. S. Thomas</b>   |  |   |  |



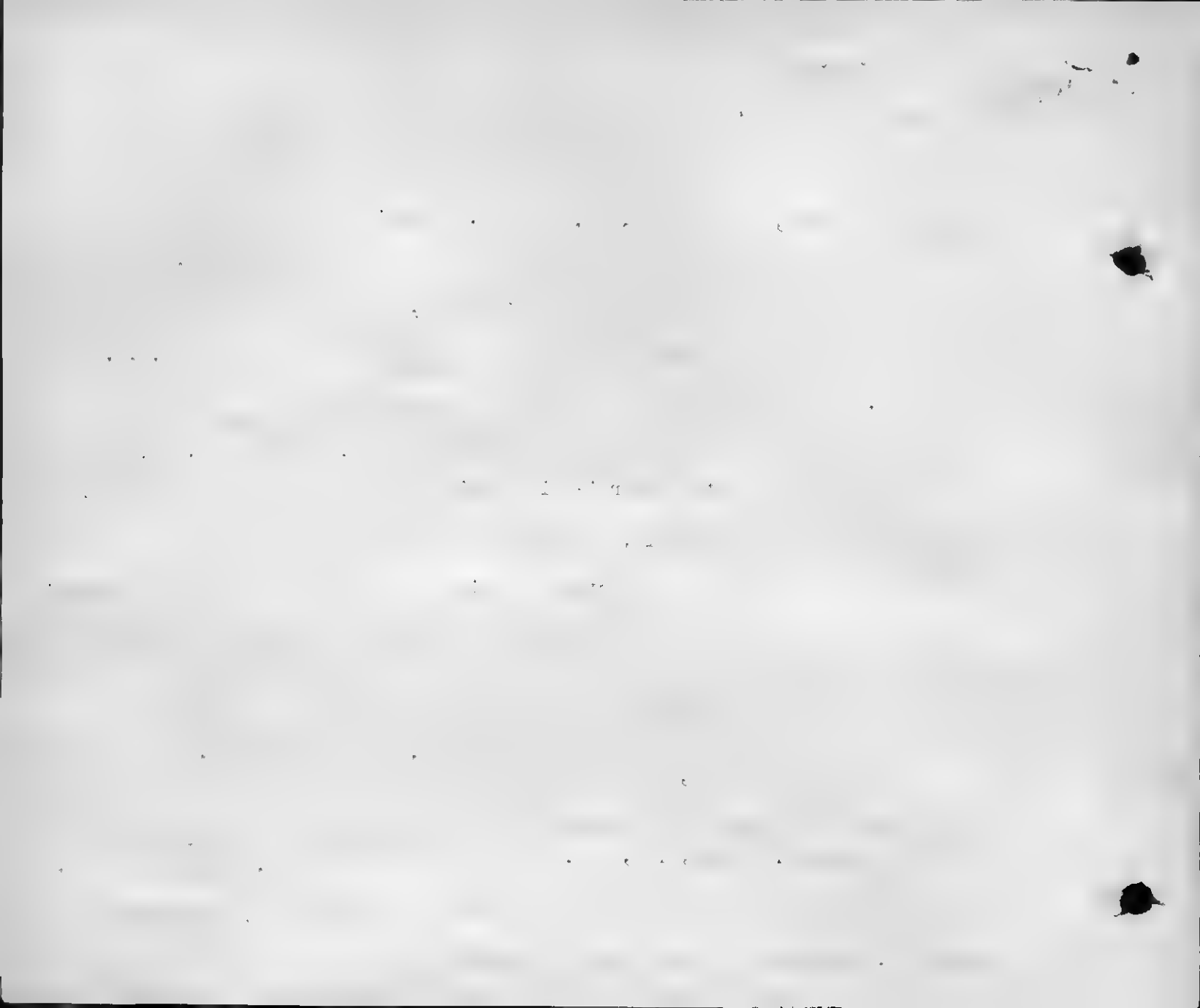






THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER THE DEATH. THE DEATH CERTIFICATE MAY BE OBTAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. THE FUNERAL DIRECTOR: AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE DETACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. THEN PLEASE REMOVE CARBON PAPERS. PAGES 1 AND 2 SHOULD BE FILLED WITH THE STATE DEPT. OF HEALTH PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT, WITHIN 72 HOURS AFTER DEATH.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |
|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |
| 14222  |  | 14192   |  |
| 1. PLACE OF DEATH  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)         |  |
| a. COUNTY <u>Montgomery</u>  |  | a. STATE <u>Georgia</u>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  | b. COUNTY <u>Claxton</u>  |  |
| c. LENGTH OF STAY IN 1b <u>30 Days</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>42x 3</u> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>  |  | d. STREET ADDRESS <u>P.O. Box 426</u>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Susan</u>   |  | 4. DATE OF DEATH <u>December 6, 19 61</u>   |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <u>None</u>  |  | 8. DATE OF BIRTH <u>December 21, 1956</u>   |  |
| 9. AGE (In years, last birthday) <u>4</u> yrs.   |  | 10. AGE (In years, last birthday) <u>4</u> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>                            |  |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>Lawton D. Scott</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Loretta Barrow</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |  | 16. SOCIAL SECURITY NO. <u>None</u>   |  |
| 17. INFORMANT <u>The Medical Records</u>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]                     |  |
| PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>   |  | INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>   |  |
| 204.3 DUE TO (b) <u>Septicemia, probably staphylococci</u>   |  | 18 hours  |  |
| DUE TO (c) <u>Acute lymphocytic leukemia</u>   |  | 15 months   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>The Clinical Center, Bethesda 14, Maryland</u>   |  |   |  |
| 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u>   |  |   |  |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  |
| 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>November 6, 1961</u> to <u>December 6, 1961</u> that (I) (we) last saw the deceased alive on <u>December 6, 1961</u> , and that death occurred at <u>1:55 PM</u> from the causes and on the date stated above |  |   |  |
| 22a. SIGNATURE <u>Thorne S. Winter, III, M.D.</u>  |  |   |  |
| 22b. DATE SIGNED <u>12/6/61</u>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Thorne S. Winter, III, M.D.</u>  |  |   |  |
| 22d. ADDRESS <u>Institutes Of Health, Bethesda 14, Md.</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |   |  |
| 23b. DATE THEREOF <u>12/7/61</u>   |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Brewton Cemetery</u>   |  |   |  |
| 23d. LOCATION (City, town or county) (State) <u>Evans Co. Georgia</u>  |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>   |  |   |  |
| 25a. REC'D BY REGISTRAR <u>DATE DEC 8 '61</u>  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director shall fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 1-1198

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  | USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. COUNTY <u>Bethesda, Md</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Montgomery County</u>        |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>—  |  | d. STREET ADDRESS<br><u>16416 Tudor Terrace</u>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>MARY</u> Middle <u>SEEBACK</u> Last<br>5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>8-26-61</u> 9. AGE (In years last birthday) <u>3</u> 10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>14</u> Hours <u>—</u> Min. <u>—</u> |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>10</u> Year <u>1961</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>—   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>—  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Wash. D.C.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Harry P. Seebach</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Jean E. Cissel</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>—</u>   |  |
| 17. INFORMANT<br><u>Harry P. Seebach</u>   |  | Address<br><u>2 D.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Malnutrition</u><br><u>757.3</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenital Heart - Cerebral Palsy Birth</u><br>(c) <u>Hydrocephalic Kidney - Glaucoma Birth</u>          |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>—</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)<br><u>—</u>   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><u>—</u>             |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. p. m. <u>19</u>   |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>           |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>—</u>   |  | 20f. (City or town) (County) (State)<br><u>—</u>  |  |
| 21. I certify that I attended the deceased from <u>8-26-1961</u> to <u>12-10-1961</u> , that I last saw the deceased alive on <u>12-10-1961</u> , and that death occurred at <u>9:10 P.M.</u> from the causes and on the date stated above.  |  |   |  |
| ACTUAL SIGNATURE<br><u>Robert D. Crawley</u> M.D. <u>5506</u>  |  | ADDRESS (Street, city or town, state)<br><u>from the M.W. Wash</u>  |  |
| DATE SIGNED<br><u>12-10-61</u>   |  | DATE SIGNED<br><u>12-10-61</u>  |  |
| PHYSICIAN'S NAME (Type)<br><u>—</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>12/13/61</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Georgetown Cemetery</u>   |  | 22d. LOCATION (City, town, of county) (State)<br><u>Georgetown 9A.</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Wendy Houlton - 4748 - Wash. Gr.</u>  |  | 24a. REC'D. BY REGISTRAR<br><u>—</u>  |  |
| ADDRESS<br><u>—</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>—</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours, after death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is fully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

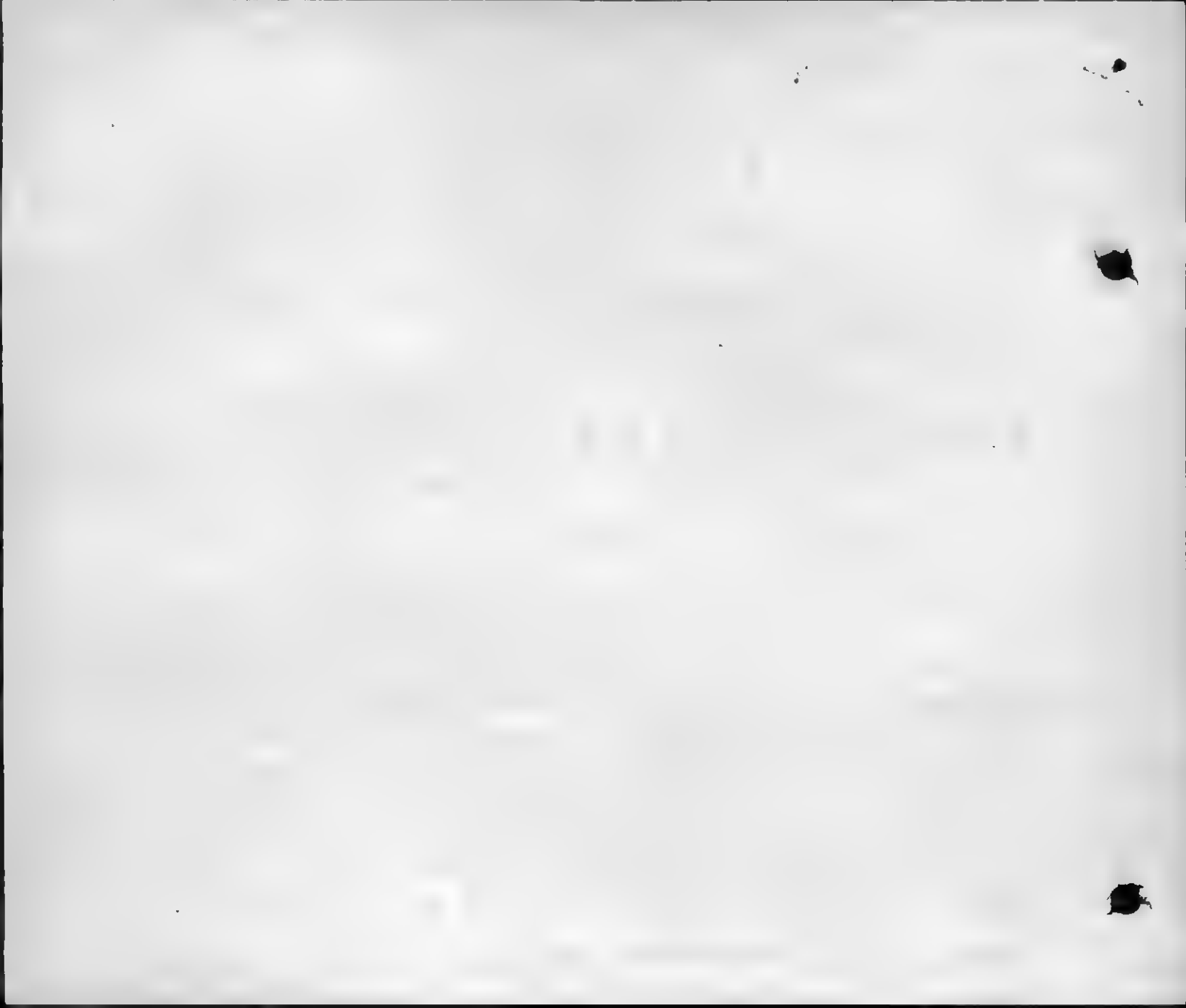
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14224

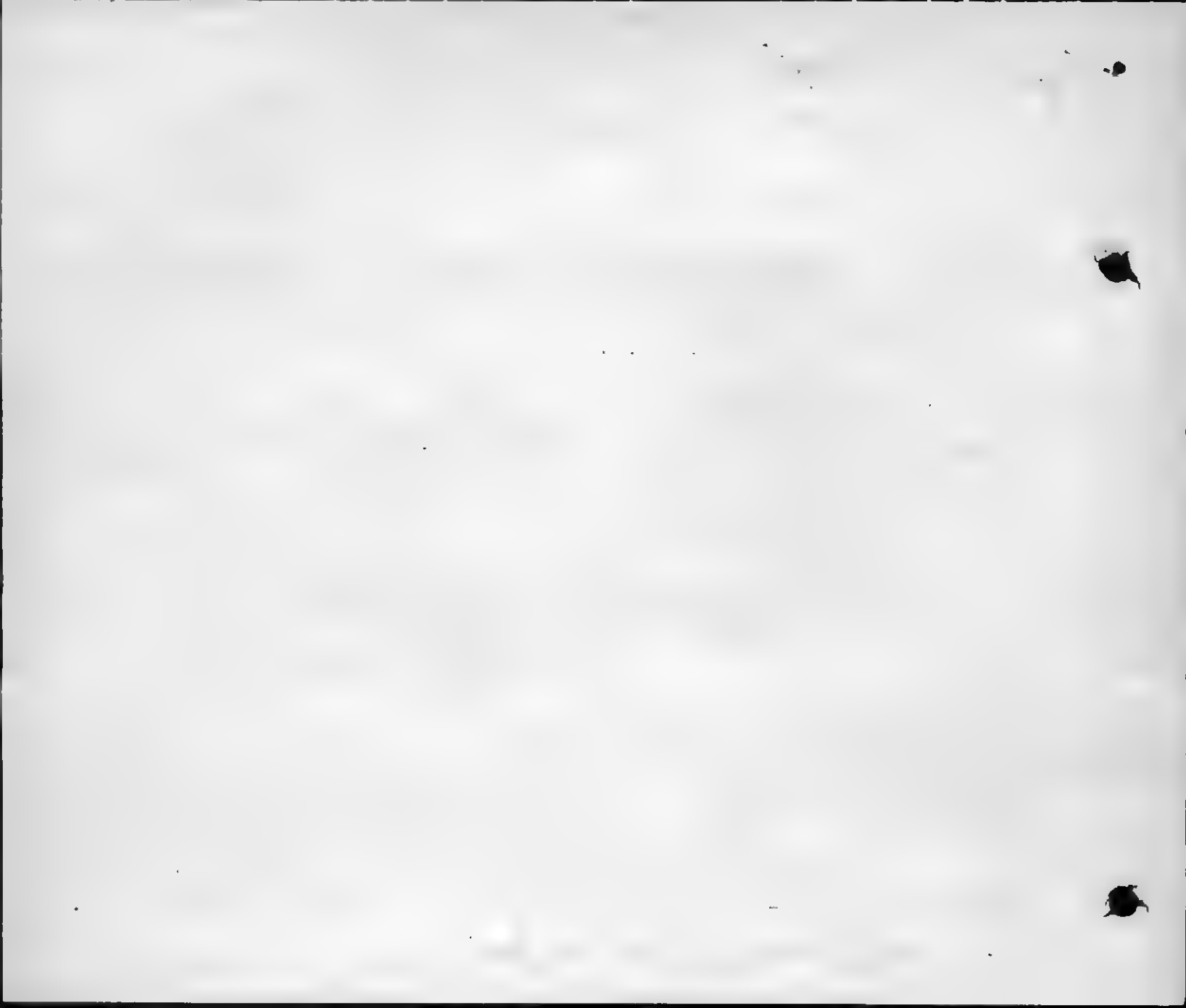
14194

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> LENGTH OF STAY IN TB <u>1 day</u><br>c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>md.</u> b. COUNTY <u>Mont.</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u><br>d. STREET ADDRESS <u>5404 Wooten Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <u>RUTH</u> First Middle Last <u>E. BOND SHOEMAKER</u>   | 4. DATE OF DEATH <u>12</u> Month <u>11</u> Day <u>1961</u> Year | 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>4/12/88</u> 73 yrs. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elementary teacher</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Samuel L Bond</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Hattie Hudson</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>   |   | 16. SOCIAL SECURITY NO <u>578-48-2722</u> 17. INFORMANT <u>Donald Shoemaker</u> Address <u>4707 Weyancon Rd. Bethesda, Md.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>332X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u><br>(a), stating the underlying cause last. DUE TO (c)<br>PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> <u>Stomachal ulcer</u> |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>  |   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/29</u> <u>1961</u> , to <u>12/11</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>12/11</u> <u>1961</u> , and that death occurred at <u>4:52</u> PM, from the causes and on the date stated above.   |   |   |  |
| 22a. SIGNATURE <u>G. L. Marks</u>  |   | 22b. DATE SIGNED <u>12-11-61</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>I. L. MARKS, M.D.</u>  |   | 22d. ADDRESS <u>6386 Wiscaron Ave. Ch. Ch. Md.</u>  |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>   |   | 23b. DATE THEREOF <u>12/14/61</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Elderbrook Church Cem.</u>   |   | 23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>   |   | 24. ADDRESS <u>Bethesda, Maryland</u>   |  |
| 25a. REC'D BY REGISTRAR <u>DEC 15 61</u>   |   | 25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>  |  |









1  
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14226

14196

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (rural)</b><br>c. LENGTH OF STAY IN b<br><b>1 day</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>U.S. Naval Hospital</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Virginia</b><br>b. COUNTY<br><b>Manassas</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>109 Perce St.</b><br>d. STREET ADDRESS<br><b>109 Perce St.</b> |  | a. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Rochelle Marie Simond</b>  |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>26</b> Year <b>1961</b>  |  | 9. AGE (In years last birthday)<br>yrs. <b>6</b> Mths <b>3</b> Days <b>3</b>                      |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Cauc</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>             |  |
| 8. DATE OF BIRTH<br><b>June 23, 1961</b>  |  | 9. AGE (In years last birthday)<br>yrs. <b>6</b> Mths <b>3</b> Days <b>3</b>  |  | 10. IF UNDER 1 YEAR<br>Hours <b>3</b> Mins <b>3</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>                            |  |
| 13. FATHER'S NAME<br><b>Roger Comile Simond</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ofelina Hernandez</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Father Roger Comile Simond Same as 2</b>                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Leukemia, Acute lymphatic</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  | INTERVAL BETWEEN ONSET AND DEATH  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b> p.m.                               |  |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Dec 26</b> , 1961 to <b>Dec 26</b> , 1961, that <del>he</del> (we) last saw the deceased alive on <b>Dec 26</b> , 1961, and that death occurred at <b>10:55 PM</b> the causes and on the date stated above.  |  |   |  |   |  |
| 22a. SIGNATURE<br><b>L.P. Scott</b>   |  | 22b. DATE SIGNED<br><b>12-27-61</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>L.P. Scott, LCDR MC USN</b>                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>30 Dec 1961</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>                                   |  |
| 23d. LOCATION (City, town or county)<br><b>Arlington, Virginia</b>  |  | 23e. REC'D BY REGISTRAR<br><b>DEC 29 '61</b>  |  | 23f. REGISTRAR'S SIGNATURE<br><b>Clifford S. ...</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Baker and Son Funeral Home</b>   |  | 24a. ADDRESS<br><b>Manassas, Virginia</b>   |  | 24b. DATE<br><b>DEC 29 '61</b>  |  |

2000

11

*[Faint, illegible markings]*

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# MARYLAND STATE DEPARTMENT OF HEALTH

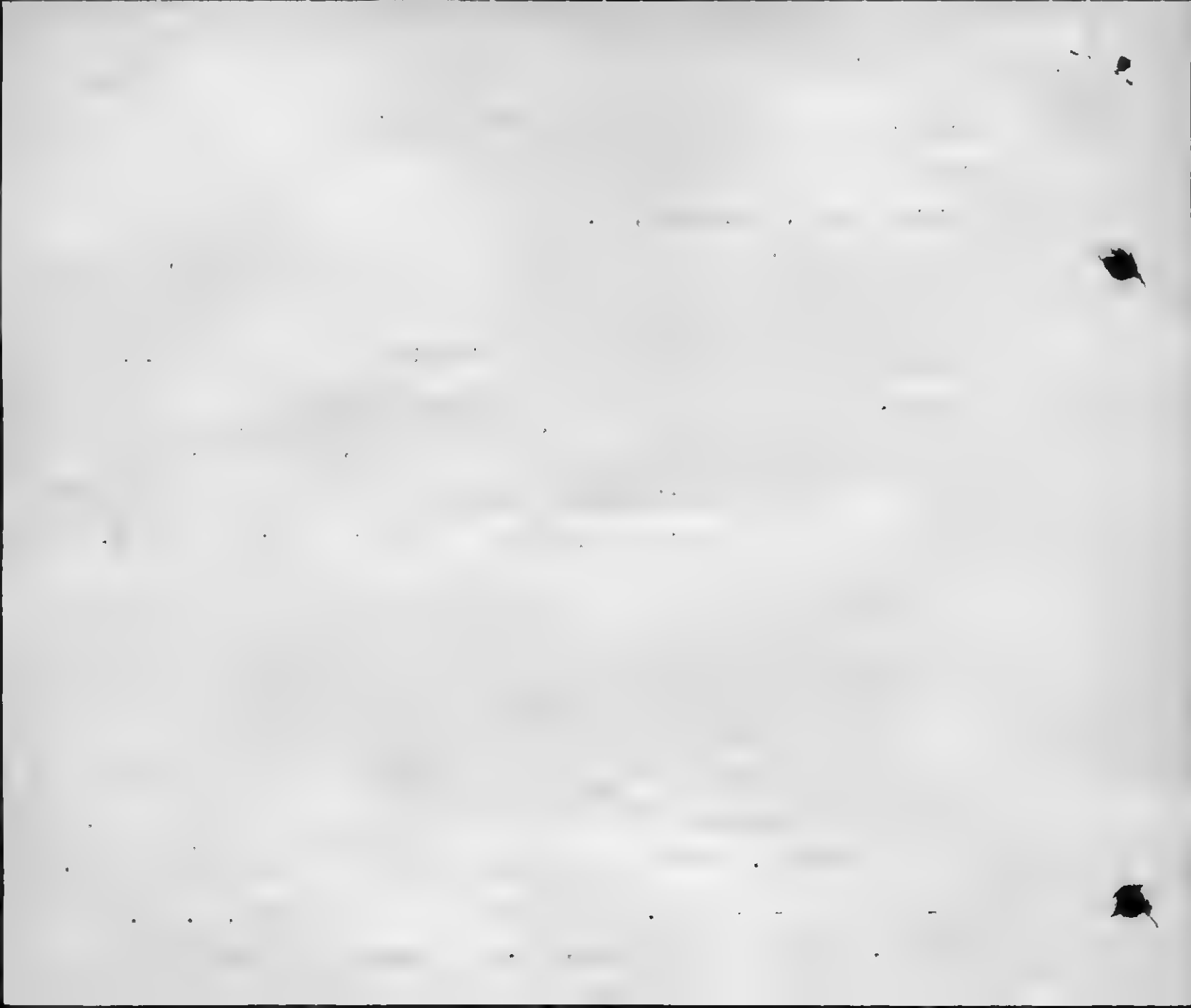
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14227

14197

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY<br>Montgomery<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Bethesda<br>c. LENGTH OF STAY IN b<br>8 days<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>The Clinical Center, Bethesda 14, Md.   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>West Virginia<br>b. COUNTY<br>Romney<br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>None<br>d. STREET ADDRESS<br>None |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>Jennifer<br>First<br>Ann<br>Middle<br>Solan<br>Last   |  | <b>4. DATE OF DEATH</b><br>Month<br>December<br>Day<br>28<br>Year<br>19 61  |  |
| <b>5. SEX</b><br>Female<br><b>6. COLOR OR RACE</b><br>White<br><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b><br>1 October 1961<br>19. AGE (in years last birthday) 2 yrs. 27 Months 27 Days 27 Hours Min.   |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>Infant<br><b>11. BIRTHPLACE</b> (County & State, or foreign country)<br>Virginia<br><b>12. CITIZEN OF WHAT COUNTRY?</b><br>U.S.A.                                    |  |
| <b>13. FATHER'S NAME</b><br>George M. Solan<br><b>14. MOTHER'S MAIDEN NAME</b><br>Marjorie Sonnenann   |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)<br>No<br><b>16. SOCIAL SECURITY NO.</b><br>None<br><b>17. INFORMANT</b><br>The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland         |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive Heart Failure<br>754.5 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) Congenital Heart Disease (Tricuspid atresia)<br>(c) DUE TO<br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br>2 mo. 27 days  |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. 19 p.m.<br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State) |  | <b>21. I certify that</b> (this hospital) attended the deceased from December 20, 1961 to December 28, 1961, that (s) (we) last saw the deceased alive on December 28, 1961, and that death occurred at 10:20 AM, from the causes and on the date stated above.           |  |
| <b>22a. SIGNATURE</b><br><i>Richard P. Anderson</i><br><b>22c. PHYSICIAN'S NAME</b> (Type)<br>Richard P. Anderson  |  | <b>22b. DATE SIGNED</b><br>December 28, 1961<br><b>22d. ADDRESS</b><br>The Clinical Center, National Institutes of Health, Bethesda 14, Md.   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br>Burial-transit 12-28-61<br><b>23b. DATE THEREOF</b><br>12-28-61<br><b>23c. NAME OF CEMETERY OR CREMATORY</b><br>Mt. Olivet Cemetery<br><b>23d. LOCATION</b> (City, town or county) (State)<br>Moorefield, W. Va.   |  | <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br>ROBERT A. PUMPHREY<br><b>25a. REC'D BY REGISTRAR</b><br>JAN 2 '62<br><b>25b. REGISTRAR'S SIGNATURE</b><br><i>Arthur S. Thomas</i>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. 1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

# MARYLAND STATE DEPARTMENT OF HEALTH

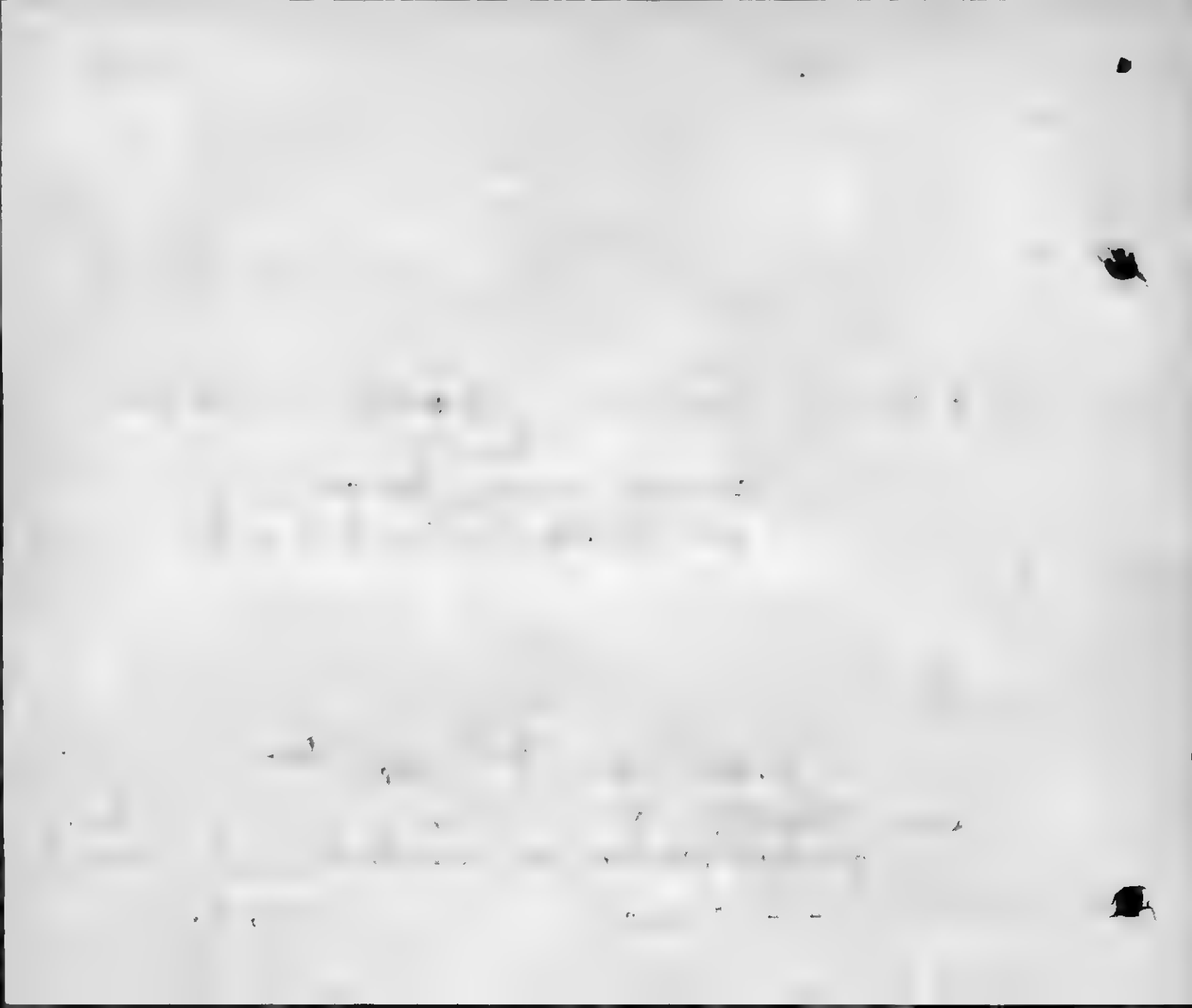
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14228

## CERTIFICATE OF DEATH

14198

| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b <u>27 weeks</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp.</u> |      |  |      | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if last full one; Residence before admission)<br>a. STATE <u>D.C.</u><br>b. COUNTY <u>D.C.</u><br>c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Washington</u><br>d. STREET ADDRESS <u>6151 31st NW</u> |  |                                     |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |                 |  |                  |  |        |      |       |      |
|---|------|--|------|---|--|-------------------------------------|--|--|--|---|--|---|--|-----------------|--|------------------|--|--------|------|-------|------|
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Margaret B. Somers</u>   |      | <b>4. DATE OF DEATH</b><br>Month <u>Dec</u> Day <u>16</u> Year <u>1961</u> |      | <b>5. SEX</b><br><u>F</u>   |  | <b>6. COLOR OR RACE</b><br><u>W</u> |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><u>11-14-10</u>        |  | <b>9. AGE</b> (in years last birthday) <u>51</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table> |  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS. |  | Months | Days | Hours | Min. |
| IF UNDER 1 YEAR   |      | IF UNDER 24 HRS.   |      |   |  |                                     |  |  |  |   |  |   |  |                 |  |                  |  |        |      |       |      |
| Months  | Days | Hours  | Min. |   |  |                                     |  |  |  |   |  |   |  |                 |  |                  |  |        |      |       |      |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Secretary</u>   |      |  |      | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Bogley, Harting</u>   |  |                                     |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u> |  |   |  |                 |  |                  |  |        |      |       |      |
| <b>13. FATHER'S NAME</b> <u>A. Harry Borjes</u>   |      |  |      | <b>14. MOTHER'S MAIDEN NAME</b> <u>Teobbits</u>   |  |                                     |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>   |  |   |  |   |  |                 |  |                  |  |        |      |       |      |
| <b>16. SOCIAL SECURITY NO</b> <u>5075-</u>  |      |  |      | <b>17. INFORMANT</b> <u>Cardwell</u>  |  |                                     |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the cervical glands of the right side of neck</u><br>(b) <u>1475</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>2 1/2 yr.</u> |  |   |  |   |  |                 |  |                  |  |        |      |       |      |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a).</b>  |      |  |      |   |  |                                     |  |  |  |   |  |   |  |                 |  |                  |  |        |      |       |      |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |      |  |      | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |                                     |  |  |  |   |  |   |  |                 |  |                  |  |        |      |       |      |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |      |  |      | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |                                     |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  |   |  |   |  |                 |  |                  |  |        |      |       |      |
| <b>21. I certify that (I) (this hospital) attended the deceased from June 1955 to Dec 1961, that (I) saw the deceased alive on 16 Dec 1961 and that death occurred at 9:15 P.M. from the causes and on the date stated above.</b>   |      |  |      |   |  |                                     |  |  |  |   |  |   |  |                 |  |                  |  |        |      |       |      |
| <b>22a. SIGNATURE</b><br><u>Herbert Martyn Jr</u>   |      |  |      | <b>22b. DATE SIGNED</b><br><u>16 Dec 61</u>   |  |                                     |  | <b>22c. PHYSICIAN'S NAME</b> (Type) <u>HERBERT MARTYN JR</u>   |  |   |  |   |  |                 |  |                  |  |        |      |       |      |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>   |      |  |      | <b>23b. DATE THEREOF</b> <u>12-19-1961</u>  |  |                                     |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Crematory</u>  |  |   |  |   |  |                 |  |                  |  |        |      |       |      |
| <b>23d. LOCATION</b> (City, town or county) <u>Suitland, Md.</u>  |      |  |      | <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Joseph Cawlers Inc</u>  |  |                                     |  | <b>25a. REC'D BY REGISTRAR</b> <u>DEC 22 '61</u>   |  |   |  |   |  |                 |  |                  |  |        |      |       |      |
| <b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Thomas</u>  |      |  |      | <b>25c. ADDRESS</b> <u>1756 PENNSYLVANIA AVE. WASH. D.C.</u>  |  |                                     |  |  |  |   |  |   |  |                 |  |                  |  |        |      |       |      |





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

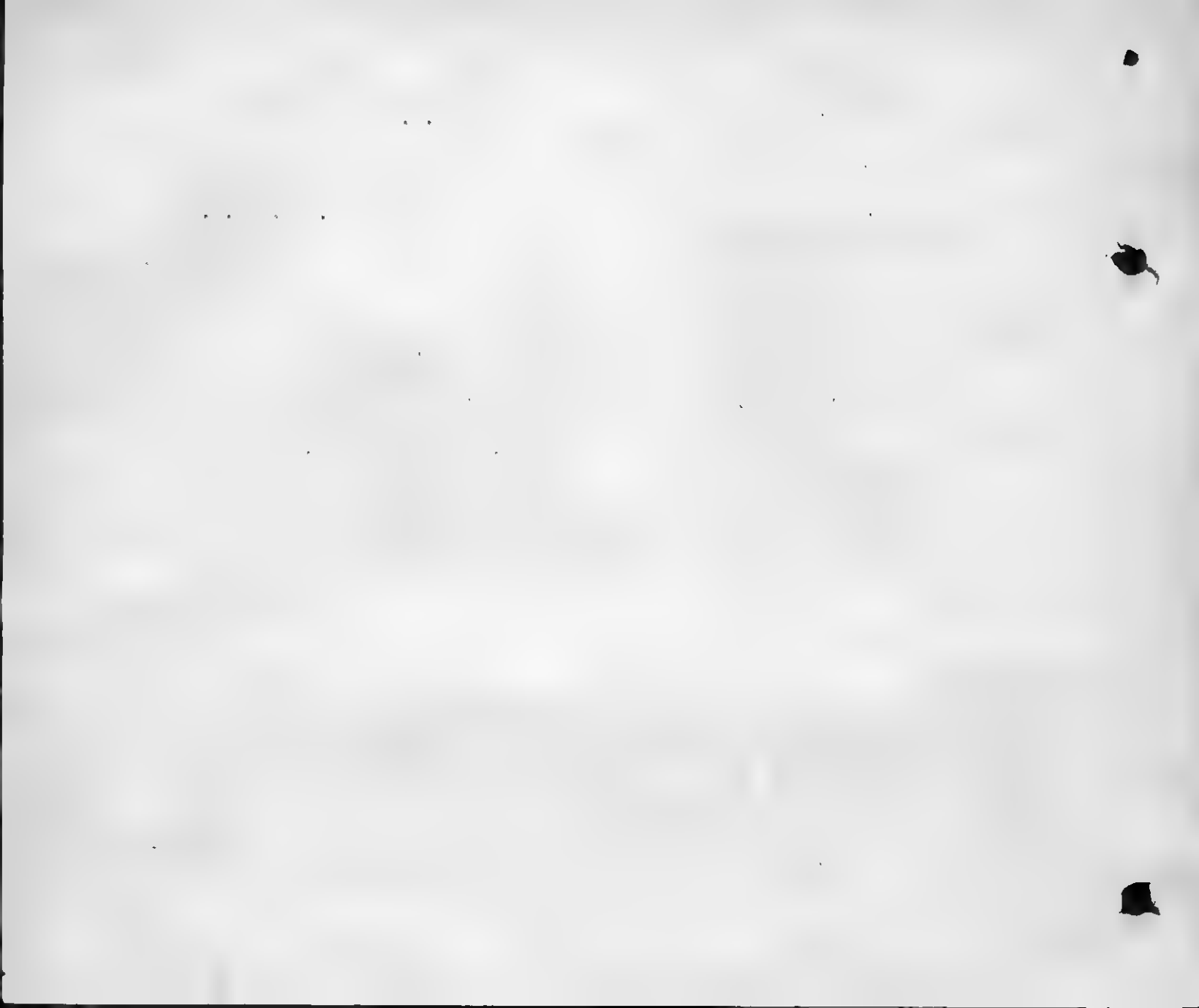
## CERTIFICATE OF DEATH

14229

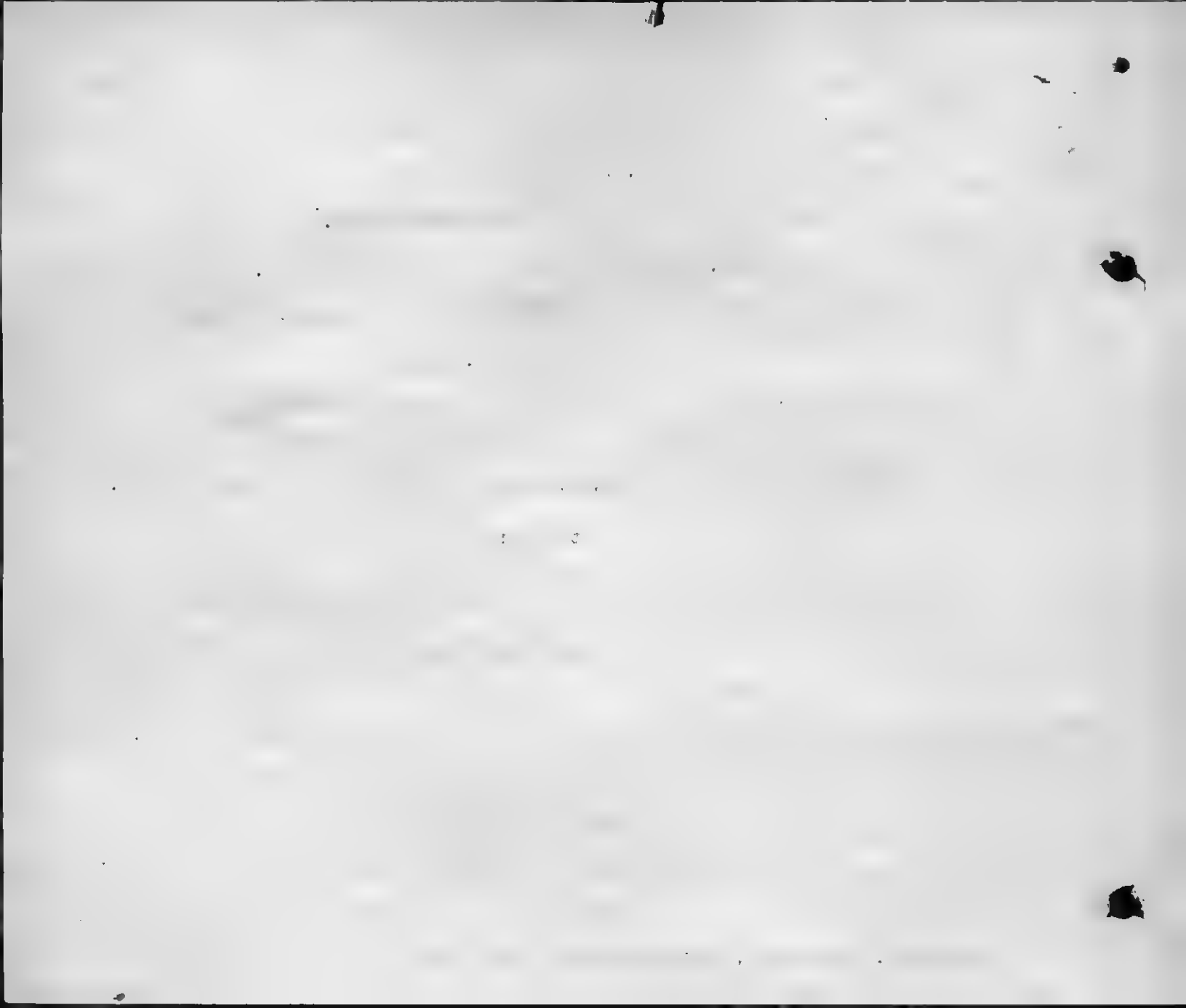
14199

|   |  |   |  |
|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u><br>c. LENGTH OF STAY IN TB<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Suburban</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>D.C.</u><br>b. COUNTY<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington</u><br>d. STREET ADDRESS<br><u>5307 42nd. St., N.W.</u><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First <u>Ada</u> Middle <u>B</u> Last <u>Spence</u><br><b>5. SEX</b><br><u>Female</u><br><b>6. COLOR OR RACE</b><br><u>White</u><br><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  |  | <b>8. DATE OF DEATH</b><br><u>December 22, 1961</u><br>Month <u>December</u> Day <u>22</u> Year <u>1961</u><br><b>9. AGE</b> (In years last birthday) <u>85</u> yrs.<br>IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u><br>IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>11. BIRTHPLACE</b> County & State, or foreign country<br><u>Maryland</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>US</u>   |  | <b>13. FATHER'S NAME</b><br><u>John Henry Spence</u><br><b>14. MOTHER'S MAIDEN NAME</b><br><u>Sarah Jane Stone</u><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u><br><b>16. SOCIAL SECURITY NO.</b><br><b>17. INFORMANT</b> Address<br><u>Neice, Theresa Spence, same as above</u>   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial decompensation with pulmonary edema</u><br>(b) <u>Myocardial degeneration, chronic</u><br>(c) <u>Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Padgett's disease</u><br><b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u><br><b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State)<br><b>21. I certify that (I) (this hospital) attended the deceased from. .... 1948 to Dec 22, 1961, that (I) last saw the deceased alive on December 21 1961, and that death occurred at 940 AM, from the causes and on the date stated above.</b><br><b>22a. SIGNATURE</b><br><u>Stewart Clapp</u><br><b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Stewart Clapp</u><br><b>22b. DATE SIGNED</b><br><u>12.22.61</u><br><b>22d. ADDRESS</b><br><u>4740 Cherry Chase St. Ch. Ch. 15th</u><br><b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u><br><b>23b. DATE THEREOF</b><br><u>12/26/61</u><br><b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Rock Creek &amp; Co.</u><br><b>23d. LOCATION</b> (City, town or county) (State)<br><u>Washington, DC</u><br><b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Cherry Chase Funeral Home</u><br><b>25a. REC'D BY REGISTRAR</b><br><u>DEC 27 '61</u><br><b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur E. Hanna</u> |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14231

14201

### 1. PLACE OF DEATH

a. COUNTY

Montgomery County

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

LENGTH OF STAY IN 1b

13 1/2 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sanitarium & Hospital

### 3. NAME OF DECEASED

(Type or print)

Joseph (N.M.N.) Startari

### 5. SEX

Male White

### 6. COLOR OR RACE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

### 8. DATE OF BIRTH

April 17 1894

### 9. AGE (in years last birthday)

67 yrs.

### 10. IF UNDER 1 YEAR

Months Days

### 11. IF UNDER 24 HRS.

Hours M.n.

### 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

(Newstand) Operator Newstand

### 10b. KIND OF BUSINESS OR INDUSTRY

### 11. BIRTHPLACE (County & State, or foreign country)

Italy

### 12. CITIZEN OF WHAT COUNTRY

United States

### 13. FATHER'S NAME

Vitale Startari

### 14. MOTHER'S MAIDEN NAME

Florence Bacqua

### 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war dates of service)

No

### 16. SOCIAL SECURITY NO.

### 17. INFORMANT

Chart

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

PNEUMONIA WITH PULMONARY CONGESTION AND EDEMA

Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last.

### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

POST OPERATIVE STATUS FROM CARCINOMA OF THE BLADDER

12 days

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.

### 22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Arthur J. White

M.D.

ATTENDING PHYS. ☒

MED. DIRECTOR ☐

STAFF PHYS. ☐

22d. ADDRESS

22b. DATE SIGNED

Dec 24-1961

### 23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

### 23b. DATE THEREOF

Dec 27, 1961

### 23c. NAME OF CEMETERY OR CREMATORIUM

George Washington

### 23d. LOCATION (City, town or county)

Hyattsville, Md.

(State)

### 24. FUNERAL DIRECTOR'S SIGNATURE

### ADDRESS

F. Gasch's Sons Hyattsville Md.

### 25a. REC'D BY REGISTRAR

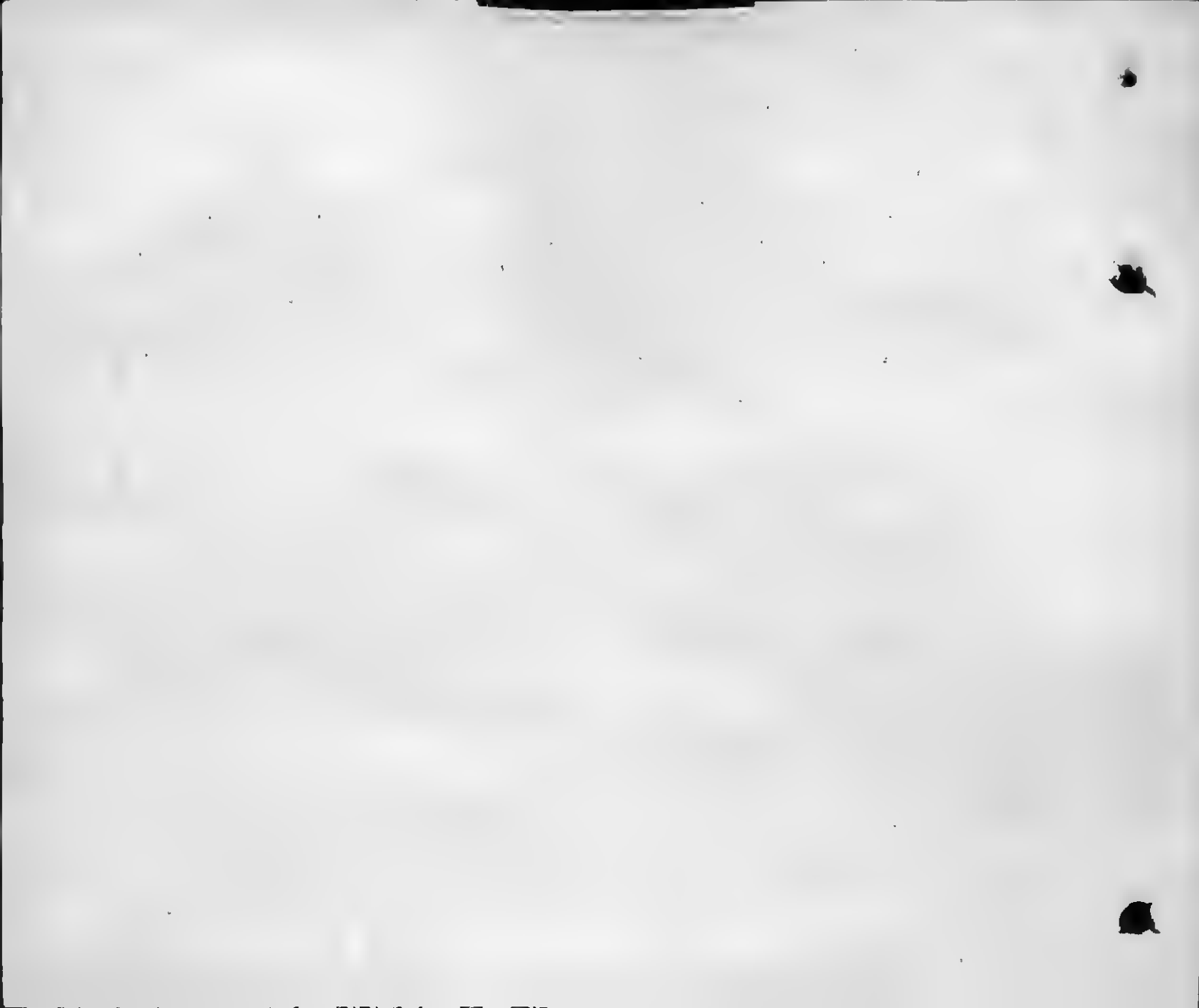
DATE JAN 2 '62

### 25b. REGISTRAR'S SIGNATURE

Arthur J. White

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

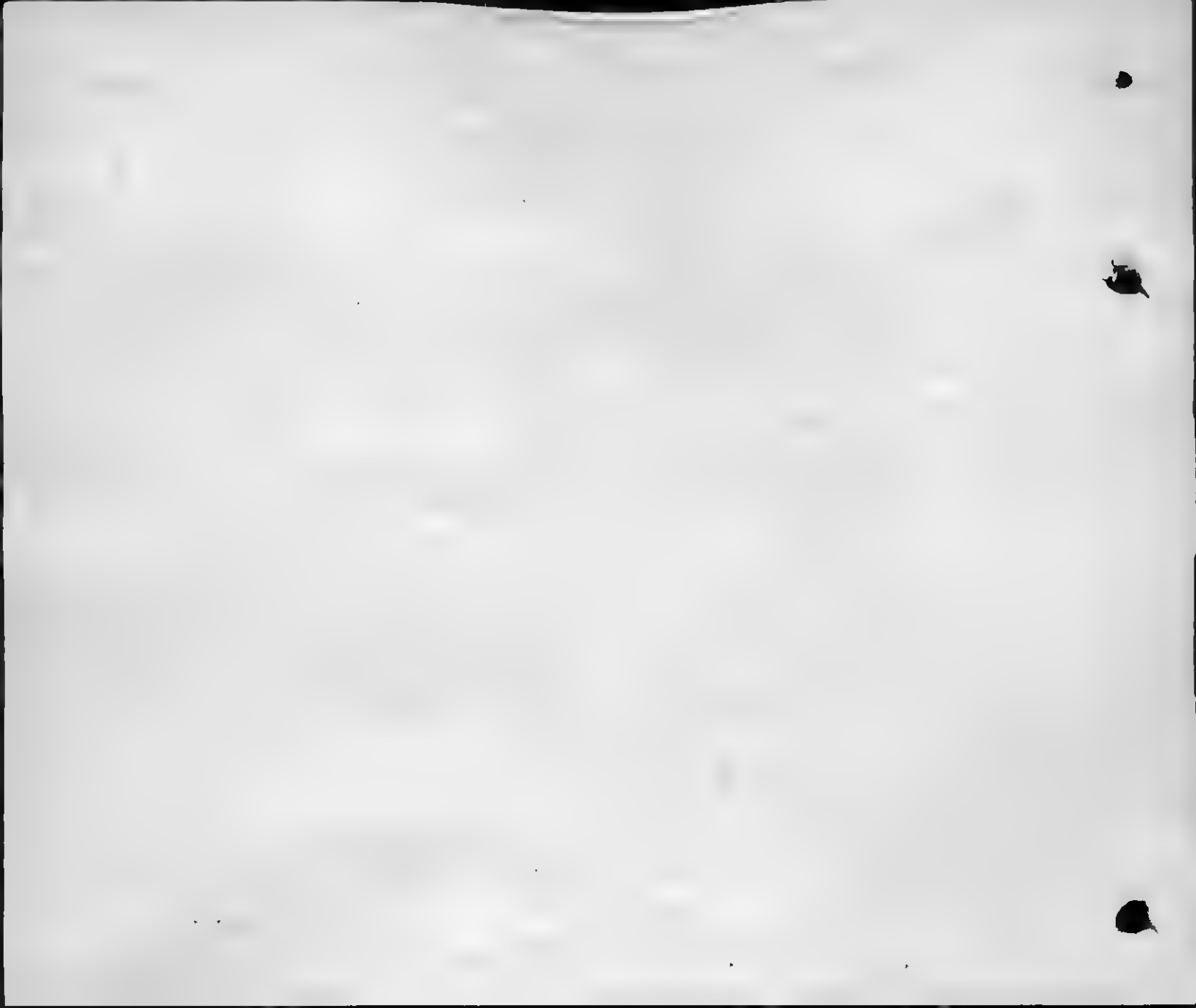


1  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

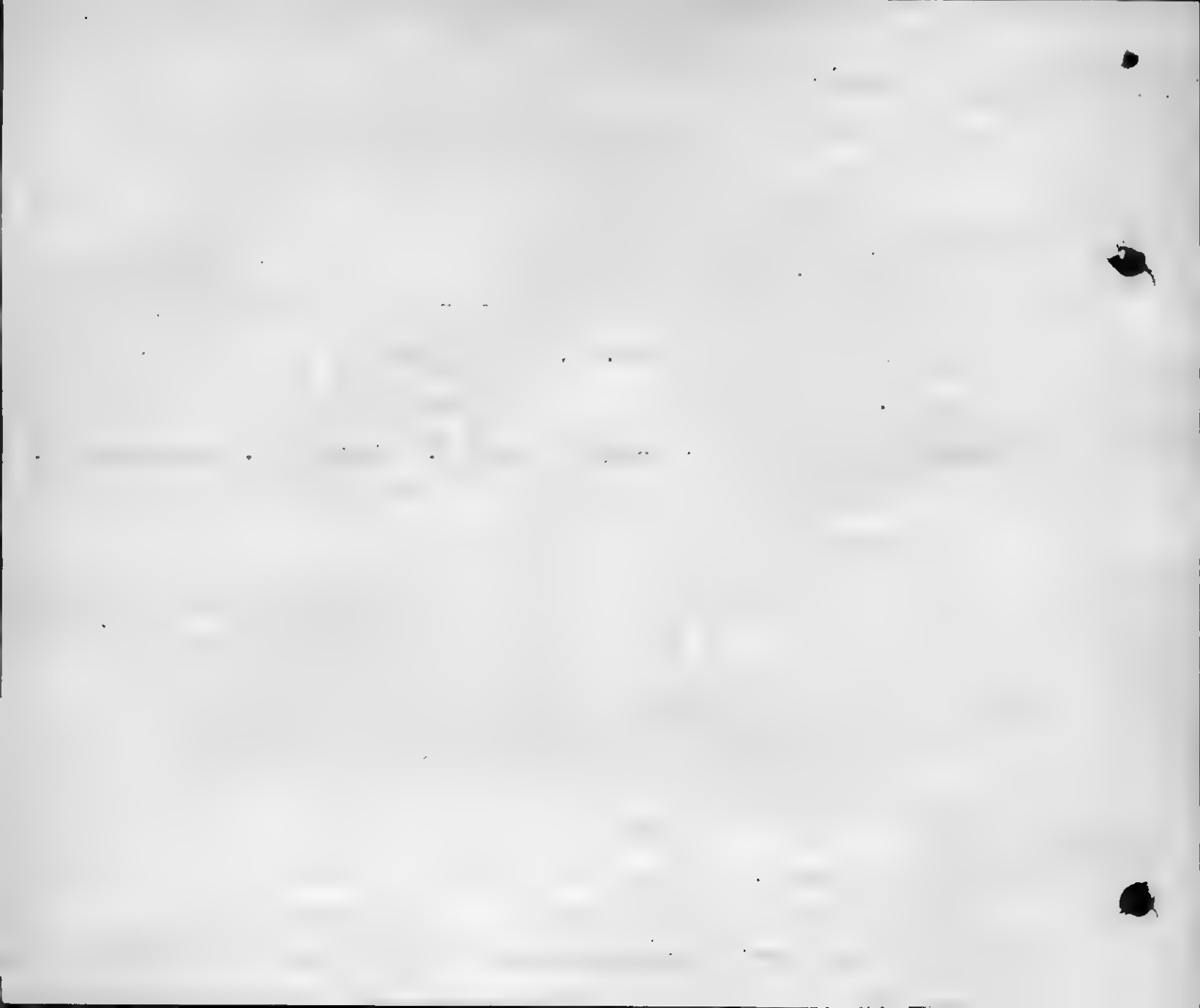
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14232 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence, or place of admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>      |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.O.A.</u>  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash San &amp; Hosp.</u>  |   | d. STREET ADDRESS <u>1902 Rosemary Hills Rd.</u>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Pearl G. Luman</u>  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>18</u> Year <u>1961</u>                                      | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-15-82</u> 79 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>JAMES Selby</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Alverda McKnew</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |   | 16. SOCIAL SECURITY NO. <u>None</u>  |  |
| 17. INFORMANT <u>Mr Charles W Stewart - Son</u>   |   | Address <u>above</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) }<br>(a), stating the underlying cause last. (c) } DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u>sudden</u> |   |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)     |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>       |   |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u>  |   | DATE SIGNED <u>12-18-61</u>  |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |   | 22b. DATE THEREOF <u>12/21/61</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>   |   | 22d. LOCATION (City, town, or country) (State) <u>Washington D.C.</u>  |  |
| 23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u> 8434 Georgia Avenue  |   | 24a. REC'D BY REGISTRAR <u>DEC 22 '61</u>  |  |
| Warner E. Pumphrey, Inc. Silver Spring, Maryland  |   | 24b. REGISTRAR'S SIGNATURE <u>Q. L. S. K. ...</u>  |  |









**MARYLAND STATE DEPARTMENT OF HEALTH**

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14234

14204

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u><br>c. LENGTH OF STAY (in days) <u>4 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutions Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>39 Silver Spring</u><br>d. STREET ADDRESS <u>10810-Keller St</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>Bulah Lee Swadley</u><br>First Middle Last<br><b>5. SEX</b> <u>female</u> <b>6. COLOR OR RACE</b> <u>white</u><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br><b>8. DATE OF BIRTH</b> <u>8/14/09</u><br><b>9. AGE</b> (in years last birthday) <u>52</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>4</u> Days <u>9</u> <b>IF UNDER 24 HRS.</b> Hours <u> </u> Min. <u> </u>   |  | <b>4. DATE OF DEATH</b> <u>Dec. 21</u> 19 <u>61</u><br>Month Day Year<br><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Home maker</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u> </u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>West Virginia</u><br><b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u><br><b>13. FATHER'S NAME</b> <u>Truman Kiser</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Virginia Reprod</u><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give order and date of service) <u>no</u><br><b>16. SOCIAL SECURITY NO.</b> <u> </u><br><b>17. INFORMANT</b> <u>Carl Swadley</u> Address <u>Above</u> |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Rectum</u><br><u>154X</u> DUE TO (b) <u> </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>  |  |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <u> </u><br><b>20c. TIME OF INJURY</b> Month, Day, Year <u> </u> <u>19</u><br>Hour a.m. <u> </u> p.m. <u> </u><br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u> </u><br><b>20f. (City or town)</b> <u> </u> <b>(Country)</b> <u> </u> <b>(State)</b> <u> </u> |  |   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec. 21, 1961</u> <b>to</b> <u>Dec. 21, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Dec. 21, 1961</u> <b>and that death occurred at</b> <u>4:30 P.M.</u> <b>from the causes and on the date stated above.</b><br><b>22a. SIGNATURE</b> <u>Belden R. Reap M.D.</u> <b>22b. DATE</b> <u>Dec. 22, 1961</u><br><b>22c. PHYSICIAN'S NAME (Type)</b> <u>BELDEN R. REAP, M.D.</u> <b>22d. ADDRESS</b> <u>WHEATON, MARYLAND</u><br><b>22e. MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>                   |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial-trans</u> <b>23b. DATE THEREOF</b> <u>12/22/1961</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Sugar Grove Cemetery</u> <b>23d. LOCATION (City, town or county)</b> <u>Sugar Grove, West Virginia</u> <b>(State)</b> <u> </u><br><b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u> <b>ADDRESS</b> <u>Bethesda, Maryland</u><br><b>25a. REC'D BY REGISTRAR</b> <u>DEC-28 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles E. K...</u>   |  |   |  |

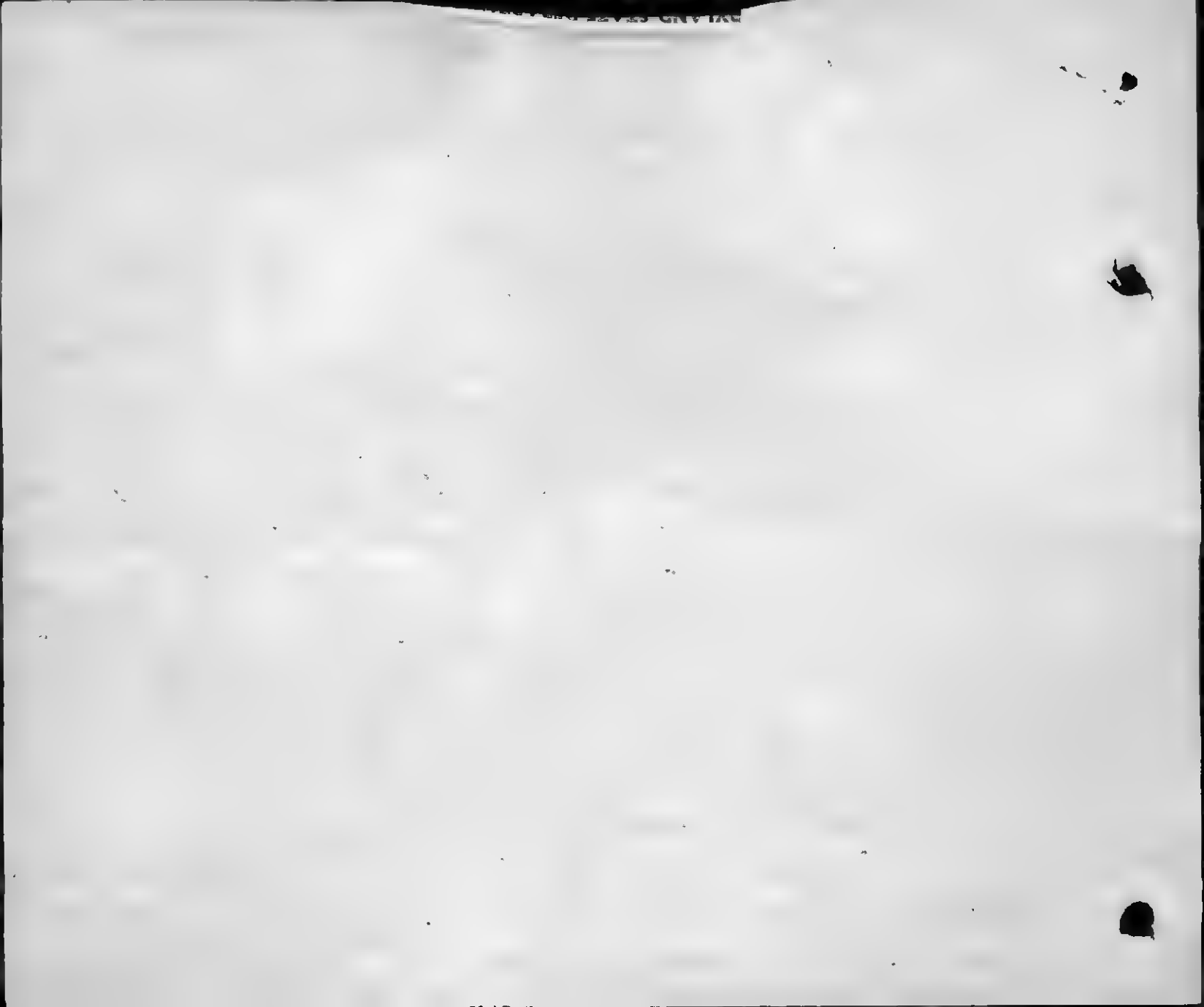


HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
11203  
14235  
CERTIFICATE OF DEATH

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>                  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  | c. LENGTH OF STAY IN 1b <u>20 minutes</u>  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  | d. STREET ADDRESS <u>8820 - River Rd.</u>    |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>  |  |  |  | a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Infant Girl Swain</u>  |  |  |  | 4. DATE OF DEATH <u>Dec. 10 1961</u>   |  |  |  |
| 5. SEX <u>female</u>  |  | 6. CO. OR RACE <u>white</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>12/10/61</u>             |  |
| 9. AGE (In years last birthday) <u>20 min</u>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> |  |
| 13. FATHER'S NAME <u>Freemont Swain</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Stacy Ann Cunningham</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO. <u>mother's chart -</u>  |  |  |  |
| 17. INFORMANT <u>mother's chart -</u>   |  |  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>152X</u> DUE TO <u>ANOXIA</u>  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>20 MIN</u>   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>HYDROCEPHALUS</u>   |  |  |  | DEVELOPMENTAL  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>CONGENITAL MALFORMATION DEVELOPMENTAL</u>   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I. of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year <u>12/10/61</u>  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/10/61</u> to <u>12/10/61</u> , that (I) (we) last saw the deceased alive on <u>12/10/61</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above. |  |  |  |  |  |  |  |
| 22a. SIGNATURE <u>Charles J. Savarese</u> M.D.  |  |  |  | 22b. DATE SIGNED <u>12/11/61</u>   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE MD</u>  |  |  |  | 22d. ADDRESS <u>4890 BATTERY LANE BETHESDA MD</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |  |  | 23b. DATE THEREOF <u>12/12/61</u>  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>   |  |  |  | 23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>  |  |  |  | 25a. REC'D BY REGISTRAR <u>DEC 13 1961</u>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <u>Carroll L. Kane</u>   |  |  |  |  |  |  |  |

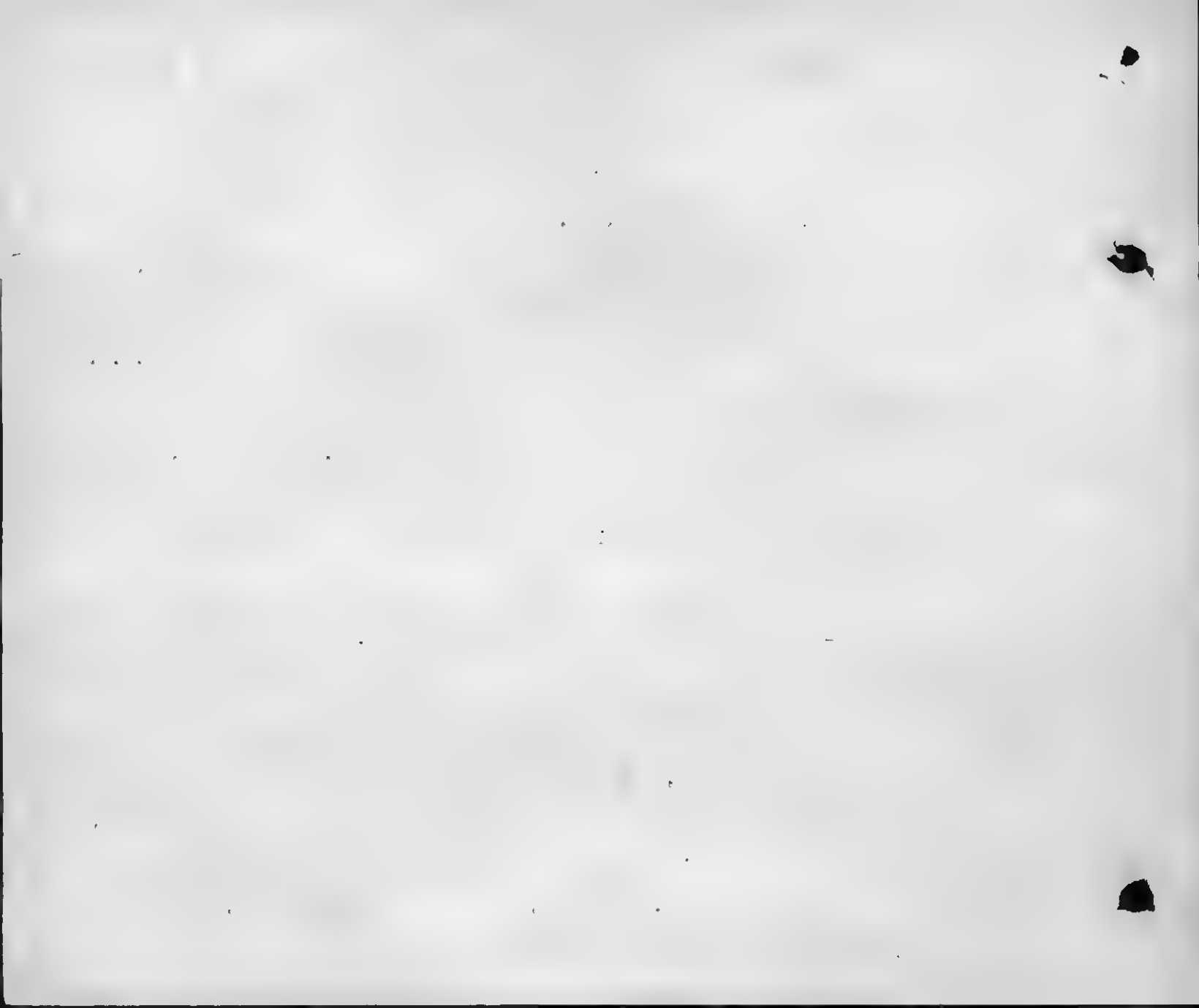
OR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and the rest of the certificate filled in by the funeral director. After this certificate has been signed by the attending physician and the rest of the certificate filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |   |  |  |  |  |
| 14236   |  |  |  |  | 14206   |  |  |  |  |
| 1. PLACE OF DEATH   |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)   |  |  |  |  |
| a. COUNTY<br><u>Montgomery</u>  |  |  |  |  | a. STATE<br><u>West Virginia</u>  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  |  |  |  | b. COUNTY<br><u>Charleston</u>  |  |  |  |  |
| c. LENGTH OF STAY IN 1b<br><u>21 days</u>   |  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>1552 Bridge Road</u>                                 |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>The Clinical Center, Bethesda 14, Md.</u>  |  |  |  |  | d. STREET ADDRESS<br><u>1552 Bridge Road</u>  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Frederica (None) Talbot</u>   |  |  |  |  | DATE OF DEATH<br><u>December 25, 1961</u>   |  |  |  |  |
| 5. SEX<br><u>Female</u>   |  |  |  |  | 9. AGE (In years if under 1 year; if under 24 hrs. last birthday) <u>57</u> yrs. <u>8</u> months <u>0</u> days <u>0</u> hours <u>0</u> min. |  |  |  |  |
| 6. COLOR OR RACE<br><u>White</u>  |  |  |  |  | 8. DATE OF BIRTH<br><u>April 25, 1904</u>   |  |  |  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Secretary</u>                              |  |  |  |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Church</u>  |  |  |  |  | 11. BIRTHPLACE (County & State or foreign country)<br><u>West Virginia</u>  |  |  |  |  |
| 13. FATHER'S NAME<br><u>Frederick Dalzell</u>   |  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Peyton</u>  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |  |  |  |  | 17. INFORMANT<br><u>The Medical Record</u>  |  |  |  |  |
| 16. SOCIAL SECURITY NO.<br><u>Unavailable</u>   |  |  |  |  | Address<br><u>The Clinical Center, Bethesda 14, Maryland</u>  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>Septicemia</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><u>Pylonephritis</u><br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>a) Metastatic Breast Carcinoma</u><br><u>b) Status post-hypophysectomy</u><br><u>c) Bone marrow depression secondary to chemotherapy.</u> |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>48 hours</u>   |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |   |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><u>19</u>   |  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                   |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  |  | 20f. (City or town) (County) (State)  |  |  |  |  |
| 21. I certify that (b) (this hospital) attended the deceased from <u>December 4, 1961</u> to <u>December 25, 1961</u> that (x) (we) last saw the deceased alive on <u>December 25, 1961</u> and that death occurred at <u>6:45 AM</u> from the causes and on the date stated above.   |  |  |  |  |   |  |  |  |  |
| 22a. SIGNATURE<br><u>Michael Field</u>  |  |  |  |  | 22b. DATE SIGNED<br><u>December 26, 1961</u>  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Michael Field, M.D.</u>  |  |  |  |  | 22d. ADDRESS<br><u>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</u>  |  |  |  |  |
| 23a. BURIAL, CREMATION, or other disposal (Specify)<br><u>Burial</u>  |  |  |  |  | 23b. DATE THEREOF<br><u>12/28/1961</u>  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Matthews,</u>  |  |  |  |  | 23d. LOCATION (City, town or county) (State)<br><u>Charleston, West Virginia</u>  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey</u>   |  |  |  |  | 25a. REC'D BY REGISTRAR<br><u>DEC 28 '61</u>  |  |  |  |  |
| ADDRESS<br><u>Bethesda, Maryland</u>  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. House</u>  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
 15M 9/59

14237

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14207

|   |                                      |   |   |
|---|--------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>10815 Madison Street</b>   |                                      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Frank</b> Middle <b>Jordan</b> Last <b>Taylor</b>   |                                      | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>7</b> Year <b>1961</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>W</b>         | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 27, 1896</b>                                     |
| 9. AGE (In years last birthday)<br><b>65</b> yrs  |                                      | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>5</b> Hours <b>15</b> Min.   | 11. IF UNDER 24 HRS.<br>Hours <b>15</b> Min.                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Architect</b>   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Pennsylvania</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   |
| 13. FATHER'S NAME<br><b>Frank C. Taylor</b>   |                                      | 14. MOTHER'S NAME<br><b>Anna B. Fisher</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)<br><b>yes</b> (If yes, give war or dates of service)<br><b>W.W.I</b>  |                                      | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT<br><b>Margarett Taylor-Wife-same 2d</b>   |                                      | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO<br>(c) <b>Unknown</b> |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                      | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                      | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 1954</b> to <b>12-7-1961</b> that (I) (we) last saw the deceased alive on <b>12-7-1961</b> and that death occurred at <b>7:15 AM</b> , from the causes and on the date stated above.   |                                      |   |   |
| 22a. SIGNATURE<br><b>George Sharpe</b>  |                                      | 22b. DATE SIGNED<br><b>12-8-61</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>George Sharpe M.D.</b>   |                                      | 22d. ADDRESS<br><b>10511 Summit Ave. Kensington Md</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>12/11/61</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Cemetery</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b> |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>   |                                      | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 11 '61</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>John A. Pumphrey</b>   |                                      |   |   |

(M)

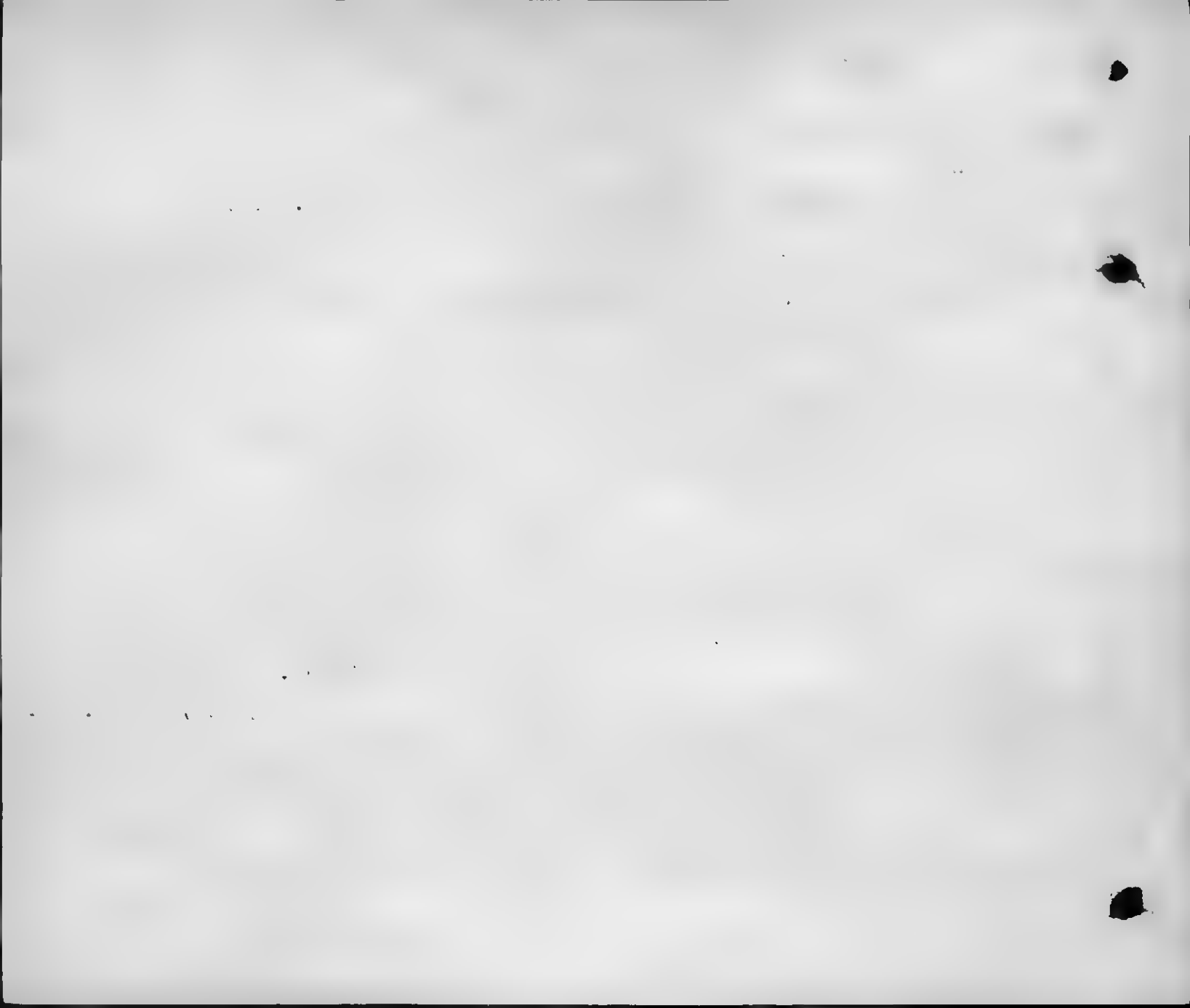
(I)

C



23. FUNERAL DIRECTOR ADDRESS DC  
*Trazier's Funeral Home, 384-RD. Ave. 7-100*

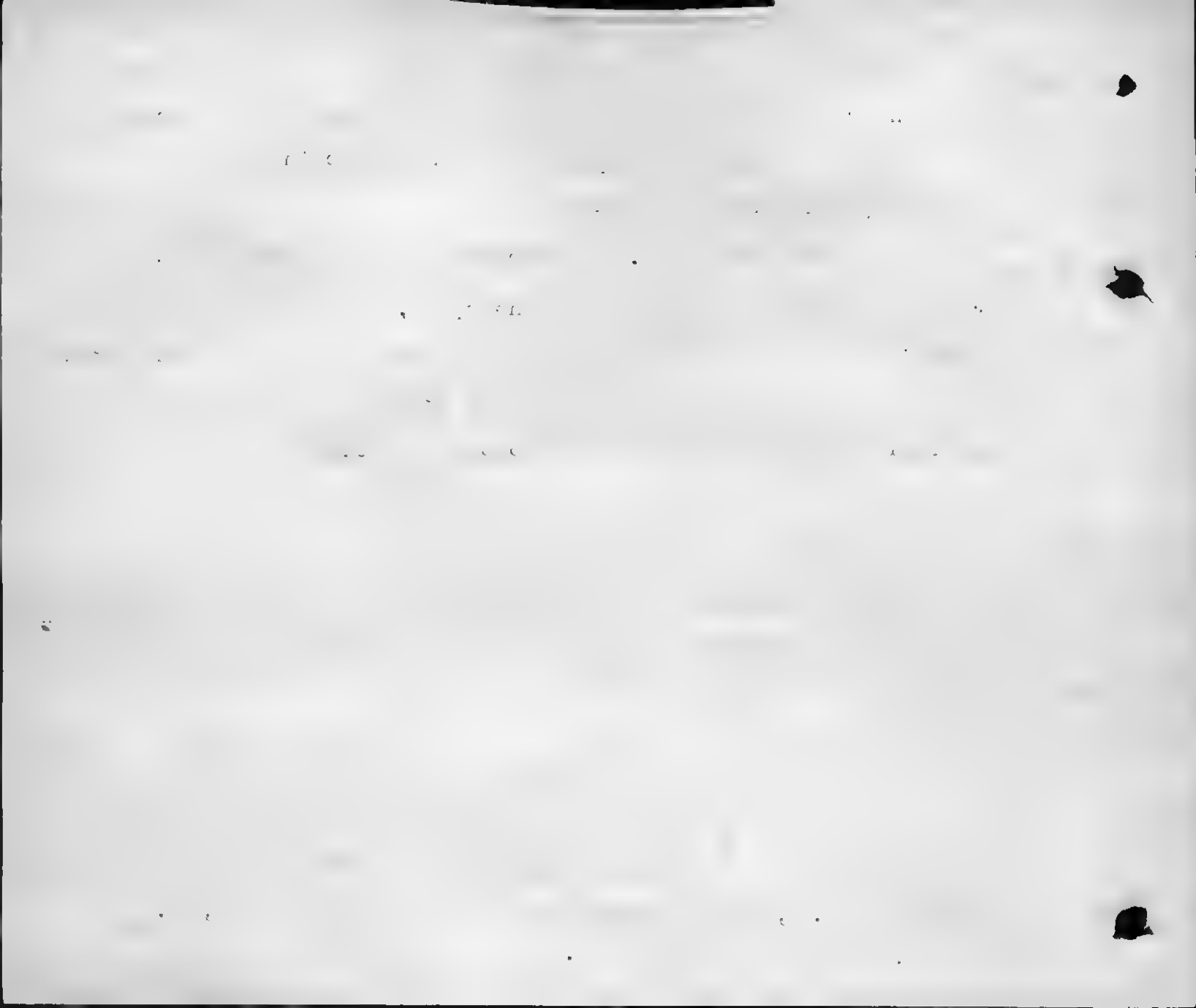
## MEDICAL CERTIFICATION



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15 (4)  
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                  |                           |  |  |   |  |                                 |                |                  |  |
|---|--|------------------|---------------------------|--|--|---|--|---------------------------------|----------------|------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                  |                           |  |  |   |  |                                 |                |                  |  |
| 14239   |  |                  |                           |  |  | 14209   |  |                                 |                |                  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b>  |  |                  |                           |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |  |                                 |                |                  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Olney</b>  |  |                  |                           |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sandy Spring</b>                                       |  |                                 |                |                  |  |
| c. LENGTH OF STAY IN 1b<br><b>5 days</b>  |  |                  |                           |  |  | d. STREET ADDRESS<br><b>X</b>   |  |                                 |                |                  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Montgomery General Hospital</b>  |  |                  |                           |  |  |   |  |                                 |                |                  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                  |                           |  |  |   |  |                                 |                |                  |  |
| 3. NAME OF DECEASED<br>(Type or print)  |  |                  | First Middle Last         |  |  | 4. DATE OF DEATH  |  |                                 | Month Day Year |                  |  |
|   |  |                  | <b>Frederic L. Thomas</b> |  |  | <b>December 31</b>  |  |                                 | <b>19 61</b>   |                  |  |
| 5. SEX  |  | 6. COLOR OR RACE |                           | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>           |  | 8. DATE OF BIRTH  |  | 9. AGE (In years last birthday) |                | IF UNDER 1 YEAR  |  |
| <b>male</b>   |  | <b>white</b>     |                           | <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b> |  | <b>January 29, 1879</b>   |  | <b>82 yrs.</b>                  |                | Months Days      |  |
|   |  |                  |                           |  |  |   |  |                                 |                | IF UNDER 24 HRS. |  |
|   |  |                  |                           |  |  |   |  |                                 |                | Hours Min.       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Banker</b>  |  |                  |                           |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Banking</b>   |  |                                 |                |                  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  |                  |                           |  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>United States</b>   |  |                                 |                |                  |  |
| 13. FATHER'S NAME<br><b>Alban Thomas</b>  |  |                  |                           |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Sue Leggett</b>  |  |                                 |                |                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give year or dates of service)<br><b>unknown</b>   |  |                  |                           |  |  | 16. SOCIAL SECURITY NO. 17. INFORMANT<br><b>Unknown Hospital Records</b>  |  |                                 |                |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>120</b> } DJE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(e), stating the underlying cause last. } DUE TO<br>(c)<br><b>Acute myocardial infarction</b> |  |                  |                           |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 wks.</b>   |  |                                 |                |                  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).  |  |                  |                           |  |  |   |  |                                 |                |                  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                  |                           |  |  |   |  |                                 |                |                  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                  |                           |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18)  |  |                                 |                |                  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>   |  |                  |                           |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                     |  |                                 |                |                  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |                  |                           |  |  | 20f. (City or town) (County) (State)  |  |                                 |                |                  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov</b> , 19 <b>61</b> , to <b>Dec</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Dec 31</b> , 19 <b>61</b> , and that death occurred at <b>5:15</b> M, from the causes and on the date stated above.                      |  |                  |                           |  |  |   |  |                                 |                |                  |  |
| 22a. SIGNATURE<br><b>A. D. Bonifant</b>   |  |                  |                           |  |  | 22b. DATE SIGNED<br><b>MD</b>   |  |                                 |                |                  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>A. D. Bonifant</b>   |  |                  |                           |  |  | 22d. ADDRESS<br><b>Sandy Spring, Md.</b>  |  |                                 |                |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                  |                           |  |  | 23b. DATE THEREOF<br><b>Jan. 3, 1962</b>  |  |                                 |                |                  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Friends Cemetery</b>   |  |                  |                           |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Sandy Spring, Md.</b>  |  |                                 |                |                  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Francis H. Barber</b>  |  |                  |                           |  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 4 '62</b>   |  |                                 |                |                  |  |
| ADDRESS<br><b>Laytonsville, Md.</b>   |  |                  |                           |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hume</b>   |  |                                 |                |                  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b <u>20 hours</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>d. STREET ADDRESS <u>116 Park Ave.</u> |  |
| 3. NAME OF DECEASED (Type or print) <u>Maudie Elizabeth Thompson</u><br>First Middle Last<br>4. DATE OF DEATH <u>12 - 31 - 1961</u><br>Month Day Year  |  | a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 5. SEX <u>Female</u><br>6. COLOR OR RACE <u>White</u><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/><br>8. DATE OF BIRTH <u>7-27-07</u><br>9. AGE (In years last birthday) <u>54</u> yrs.  |  | IF UNDER 1 YEAR Months Days<br>IF UNDER 24 HRS. Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u><br>10b. KIND OF BUSINESS OR INDUSTRY<br>11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u><br>12. CITIZEN OF WHAT COUNTRY?   |  |   |  |
| 13. FATHER'S NAME <u>Walter Gregg</u><br>14. MOTHER'S MAIDEN NAME <u>Cora Norris</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u><br>16. SOCIAL SECURITY NO. (If yes give year or dates of service)<br>17. INFORMANT <u>Hosp. Records</u><br>Address   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>4 20.1</u> DUE TO <u>Coronary Occlusion</u><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO<br>(b) (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):<br>INTERVAL BETWEEN ONSET AND DEATH <u>12/30/61</u>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)<br>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1/24/55</u> to <u>Dec. 31, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec. 31, 1961</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE <u>Howard T. Morse</u><br>22c. PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>   |  | 22b. DATE SIGNED <u>12/31/61</u><br>22d. ADDRESS <u>7030 Carver Drive Takoma Park, Md</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u><br>23b. DATE THEREOF <u>Jan. 4, 1962</u><br>23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u><br>23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>   |  | 24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>254 Carroll St. NW, Wash. DC</u><br>25a. REC'D BY REGISTRAR <u>Jan 3 '62</u><br>25b. REGISTRAR'S SIGNATURE <u>John S. Harris</u>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

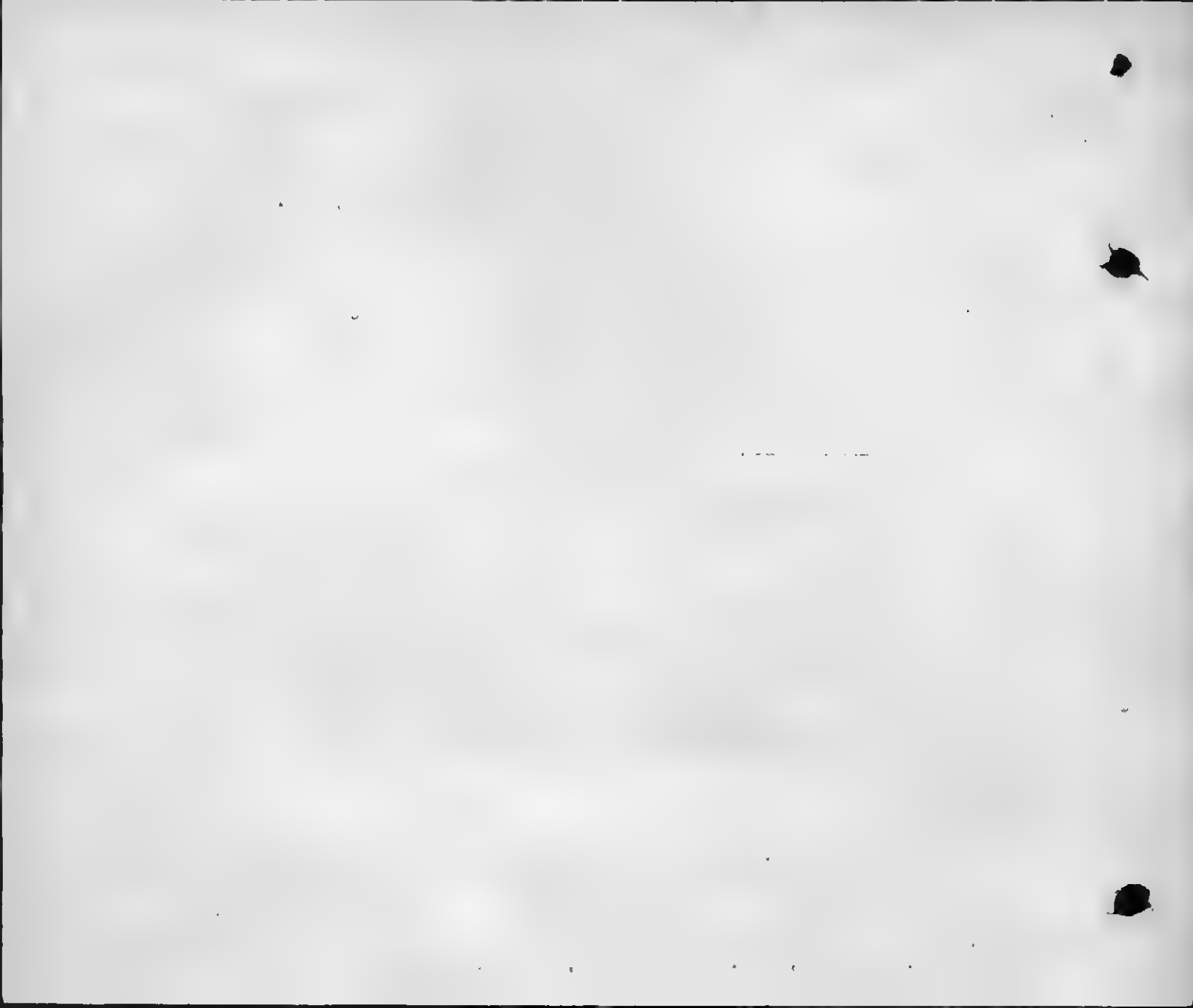
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14241

14210

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b <u>5da 15 hrs.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>                                       |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 24</u><br>d. STREET ADDRESS <u>733 Sligo Avenue, Apt. 615</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><u>Viola</u><br>First Middle Last<br><b>4. DATE OF DEATH</b><br><u>December 2 1961</u><br>Month Day Year   |  | <b>9. AGE</b> (In years, if under 1 year; last birthday)<br><u>81</u> yrs<br>Months Days Hours Min.<br><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u><br><b>11. BIRTHPLACE</b> County & State, or foreign country<br><u>Pennsylvania</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U. S. A.</u>  |  |
| <b>5. SEX</b><br><u>Female</u><br><b>6. COLOR OR RACE</b><br><u>White</u><br><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b><br><u>November 13, 1880</u><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | <b>13. FATHER'S NAME</b><br><u>John Belford</u><br><b>14. MOTHER'S MAIDEN NAME</b><br><u>Anna Heffelfinger</u><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)<br><u>No</u><br><b>16. SOCIAL SECURITY NO.</b><br><u>None</u><br><b>17. INFORMANT</b><br><u>Hospital Record.</u>   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS, GENERALIZED</u><br>DUE TO (b) <u>PRIMARY ADENOCARCINOMA, TRANSVERSE COLON - 15 MO.</u><br>DUE TO (c) <u>153.1</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b><br><b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec 2, 1961</u> <b>to</b> <u>Dec 2, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Dec 2, 1961</u> , <b>and that death occurred at</b> <u>11:45 P.M.</u> <b>from the causes and on the date stated above.</b>   |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Scruch T. Kimble</u>   |  | <b>22b. DATE SIGNED</b><br><u>DEC 5 '61</u>  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type) <u>SCRUCH T. KIMBLE</u>  |  | <b>22d. ADDRESS</b><br><u>927 Pershing Dr. Silver Spring, Md.</u>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>BURIAL</u>  |  | <b>23b. DATE THEREOF</b><br><u>12/5/61</u>   |  |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Parklawn Cemetery</u>  |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Montgomery Maryland</u>  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Raymond H. Ziska</u><br><b>25a. REC'D BY REGISTRAR</b><br><u>DEC 5 '61</u>   |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Charles S. Thomas</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

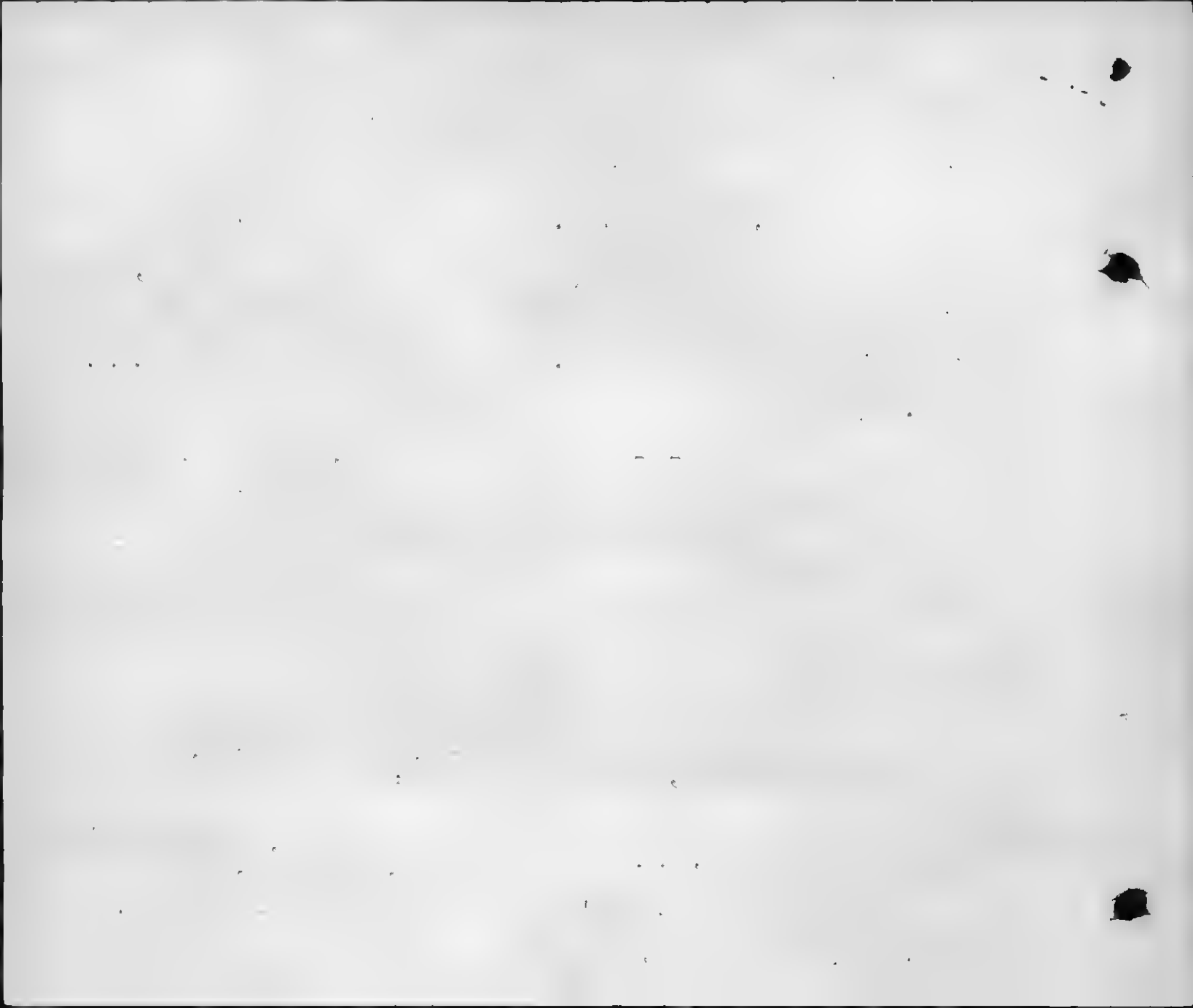
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14242

14212

|  |  |  |  |
|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY<br><u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u><br>c. LENGTH OF STAY IN 1b<br><u>111 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>The Clinical Center, Bethesda 14, Md.</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><u>Pennsylvania</u><br>b. COUNTY<br><u>Shamokin</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>142 South Franklin Street</u><br>d. STREET ADDRESS<br><u>142 South Franklin Street</u>   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><u>Stephen Lawrence Tighe</u><br>e. SEX<br><u>Male</u><br>f. COLOR OR RACE<br><u>White</u><br>g. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> h. DATE OF BIRTH<br><u>August 2, 1910</u><br>i. AGE (in years if under 1 year, if under 24 hrs., last birthday) Months Days Hours Min.<br><u>51 yrs. 4 23</u>   |  | <b>4. DATE OF DEATH</b><br><u>December 25, 1961</u><br>j. AGE (in years if under 1 year, if under 24 hrs., last birthday) Months Days Hours Min.<br><u>51 yrs. 4 23</u>  |  |
| <b>5. SEX</b><br><u>Male</u><br><b>6. COLOR OR RACE</b><br><u>White</u><br><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/><br><b>8. DATE OF BIRTH</b><br><u>August 2, 1910</u><br><b>9. AGE</b> (in years if under 1 year, if under 24 hrs., last birthday) Months Days Hours Min.<br><u>51 yrs. 4 23</u>  |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Shipper and Checker</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Dressed Beef Co.</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Pennsylvania</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>  |  |
| <b>13. FATHER'S NAME</b><br><u>John J. Tighe</u><br><b>14. MOTHER'S MAIDEN NAME</b><br><u>Mary Martin</u>  |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u><br><b>16. SOCIAL SECURITY NO.</b><br><u>178-05-1463</u><br><b>17. INFORMANT</b><br><u>The Medical Record</u><br><b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><b>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)</b><br><u>194X Carcinoma of the Thyroid gland metastatic to lungs, liver</u><br><b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b><br><b>(b)</b> <u>Congestive heart failure of unknown etiology</u><br><b>(c)</b><br><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a)</b><br><b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b><br><input type="checkbox"/><br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour e.m. p.m. <u>19</u><br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State)<br><u>September 5, 1961 to December 25, 1961</u><br><b>21. I certify that (X) (this hospital) attended the deceased from September 5, 1961 to December 25, 1961 that (X) (we) last saw the deceased alive on December 25, 1961 and that death occurred at 4:00 AM from the causes and on the date stated above.</b><br><b>22a. SIGNATURE</b><br><u>Carl J. Bantzel</u><br><b>22b. DATE SIGNED</b><br><u>December 26, 1961</u><br><b>22c. PHYSICIAN'S NAME (Type)</b><br><u>Carl J. Bantzel, M.D.</u><br><b>22d. ADDRESS</b><br><u>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</u> |  | <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u><br><b>23b. DATE THEREOF</b><br><u>12/29/1961</u><br><b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>St. Mary's</u><br><b>23d. LOCATION (City, town or county)</b> (State)<br><u>Coal Township Penna.</u><br><b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Robert A. Pumphrey</u><br><b>24b. ADDRESS</b><br><u>Bethesda, Maryland</u><br><b>25a. REC'D BY REGISTRAR</b><br><u>DEC 28 '61</u><br><b>25b. REGISTRAR'S SIGNATURE</b><br><u>Carl J. Bantzel</u>   |  |



**TOWN HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **GENERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14213

14243

|   |  |  |  |
|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN b. <u>40 Days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Nebraska</u><br>b. COUNTY <u>Papillion</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>310 Crest Road</u><br>d. STREET ADDRESS <u>Papillion</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Michael Laverne Timmerman</u><br>First Middle Last<br><b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u><br><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>February 23, 1954</u><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>7</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M n.   |  | <b>4. DATE OF DEATH</b> <u>December 2, 1961</u><br>Month Day Year<br><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Student</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Minnesota</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>   |  |
| <b>13. FATHER'S NAME</b> <u>Laverne Timmerman</u><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u><br><b>16. SOCIAL SECURITY NO.</b> <u>None</u><br><b>17. INFORMANT</b> <u>Patricia McCormick</u><br>Address <u>The Medical Records</u><br><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>(b) <u>Probable Hypoglycemia</u><br>(c) <u>Lymphosarcoma</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>metastases to mediastinum, liver, bone marrow.</u> |  | <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>two minutes</u><br><b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u><br>Hour a.m. p.m.<br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State) |  |
| <b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>October 23, 1961</u> to <u>December 2, 1961</u> that (I) (we) last saw the deceased alive on <u>December 2, 1961</u> , and that death occurred at <u>9:25 AM</u> from the causes and on the date stated above.  |  | <b>22a. SIGNATURE</b> <u>J. David Heywood</u> M.D.<br><b>22c. PHYSICIAN'S NAME</b> (Type) <u>J. David Heywood M.D.</u><br><b>22d. ADDRESS</b> <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial-transit 12-3-61</u><br><b>23b. DATE THEREOF</b> <u>12-3-61</u><br><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Papillion Cemetery</u><br><b>23d. LOCATION</b> (City, town or county) (State) <u>Papillion, Nebraska</u>  |  | <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ROBERT A. PUMPHREY</u><br>ADDRESS <u>Bethesda, Maryland</u><br><b>25a. REC'D BY REGISTRAR</b> <u>DEC 6 '61</u><br><b>25b. REGISTRAR'S SIGNATURE</b> <u>J. S. Kline</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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| MARYLAND<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND<br>14244<br>CERTIFICATE OF DEATH<br>14214  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.C.</u><br>c. LENGTH OF STAY IN 1b <u>D.O.A.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH SAN &amp; Hosp</u>      |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institutions, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u><br>d. STREET ADDRESS <u>625 Sheridan St</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>George Edgar Towles</u>  |  |  |  | 4. DATE OF DEATH <u>12-23</u> 19 <u>61</u><br>Month <u>12</u> Day <u>23</u> Year <u>1961</u>   |  |  |  | 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>11-26-97</u> 64<br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>P.O. Dept WASH D.C</u>  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>   |  |  |  |  |  |
| 13. FATHER'S NAME <u>Joseph Towles</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>FRANCES Upton</u>  |  |  |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.  |  |  |  | 17. INFORMANT Address  |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><u>331X</u> DUE TO <u>Cerebral hemorrhage</u><br><u>Cerebral atherosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (b) } DUE TO<br>(e), stating the underlying cause last. (c) } |  |  |  |  |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Subacute bronchitis</u>  |  |  |  |  |  |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                 |  | 20f. (City or town) (County) (State)   |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1</u> , 19 <u>61</u> , to <u>Dec 23</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Dec 21</u> , 19 <u>61</u> , and that death occurred at <u>330 PM</u> , from the causes and on the date stated above.                |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE <u>M. F. OTTMAN</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>12/23/61</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>M. F. OTTMAN</u>  |  |  |  | 22d. ADDRESS <u>401 Kennedy St NW</u>  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>   |  |  |  | 23b. DATE THEREOF <u>Dec 27-61</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery Rock Creek Pk. Road D.C.</u> |  | 23d. LOCATION (City, town or county) (State)   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Kline</u>   |  |  |  | ADDRESS <u>254 Carroll St. N.E.</u>  |  | 25a. RECD BY REGISTRAR <u>DEC 27 '61</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur J. Kline</u>  |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. NAME OF DECEASED (Type or print) 2. SEX 3. AGE (In years, last birthday) 4. DATE OF DEATH 5. PLACE OF DEATH 6. CITY OR TOWN 7. COUNTY 8. USUAL RESIDENCE 9. DATE OF BIRTH 10. USUAL OCCUPATION 11. BIRTHPLACE 12. CITIZEN OF WHAT COUNTRY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 18. CAUSE OF DEATH 19. WAS AUTOPSY PERFORMED? 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e. PLACE OF INJURY 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from... to... that (I) (we) last saw the deceased alive on... and that death occurred at... M, from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 22e. REC'D BY REGISTRAR 22f. REGISTRAR'S SIGNATURE 23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) 24. FUNERAL DIRECTOR'S SIGNATURE 25. DATE

| MONTGOMERY STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |   |  |  |  |  |  |  |  |
| 14245 CERTIFICATE OF DEATH 14215   |  |  |  |   |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery County</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |  |  |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>olney</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>4 1/2 days</b>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Norbeck</b> <b>14</b>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Montgomery General Hospital</b>   |  |  |  | d. STREET ADDRESS<br><b>Norwood Road</b>  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>First Middle Last</b><br><b>Curt Seydlitz</b>   |  |  |  | 4. DATE OF DEATH<br><b>December 13 1961</b>   |  |  |  |  |  |  |  |
| 5. SEX<br><b>male</b>  |  |  |  | 6. COLOR OR RACE<br><b>white</b>  |  |  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 8. AGE (In years, last birthday)<br><b>89 yrs.</b>   |  |  |  | 9. DATE OF BIRTH<br><b>March 15, 1872</b>   |  |  |  | 10. AGE (In years, last birthday)<br><b>89 yrs.</b>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unknown</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Germany</b>  |  |  |  |
| 13. FATHER'S NAME<br><b>Unknown</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>unknown</b>  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>Yes</b>   |  |  |  | 17. INFORMANT<br><b>Hospital Records</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA BILATERAL</b><br><b>491X</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIO SCLEROTIC HEART DISEASE</b><br>(c) <b>DUE TO</b> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):   |  |  |  |   |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |   |  |  |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)  |  |  |  |   |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |  |  |   |  |  |  |  |  |  |  |
| 20d. INJURY OCCURRED While at work Not While at work <input type="checkbox"/>  |  |  |  |   |  |  |  |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  |   |  |  |  |  |  |  |  |
| 20f. (City or town) (County) (State)   |  |  |  |   |  |  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12-10</b> to <b>12-13</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12/13</b> , 19 <b>61</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.                             |  |  |  |   |  |  |  |  |  |  |  |
| 22a. SIGNATURE <b>Luciano I. Leal</b> 22b. DATE <b>12/13/61</b>  |  |  |  |   |  |  |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>LUCIANO I. LEAL, M.D.</b> 22d. ADDRESS <b>GAITHERSBURG, MARYLAND</b>   |  |  |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b> 23b. DATE THEREOF <b>12/15/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b> 23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>   |  |  |  |   |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b> 25. DATE <b>DEC 18 61</b>   |  |  |  |   |  |  |  |  |  |  |  |

ATLAS of the  
Mammals of the  
State of Texas

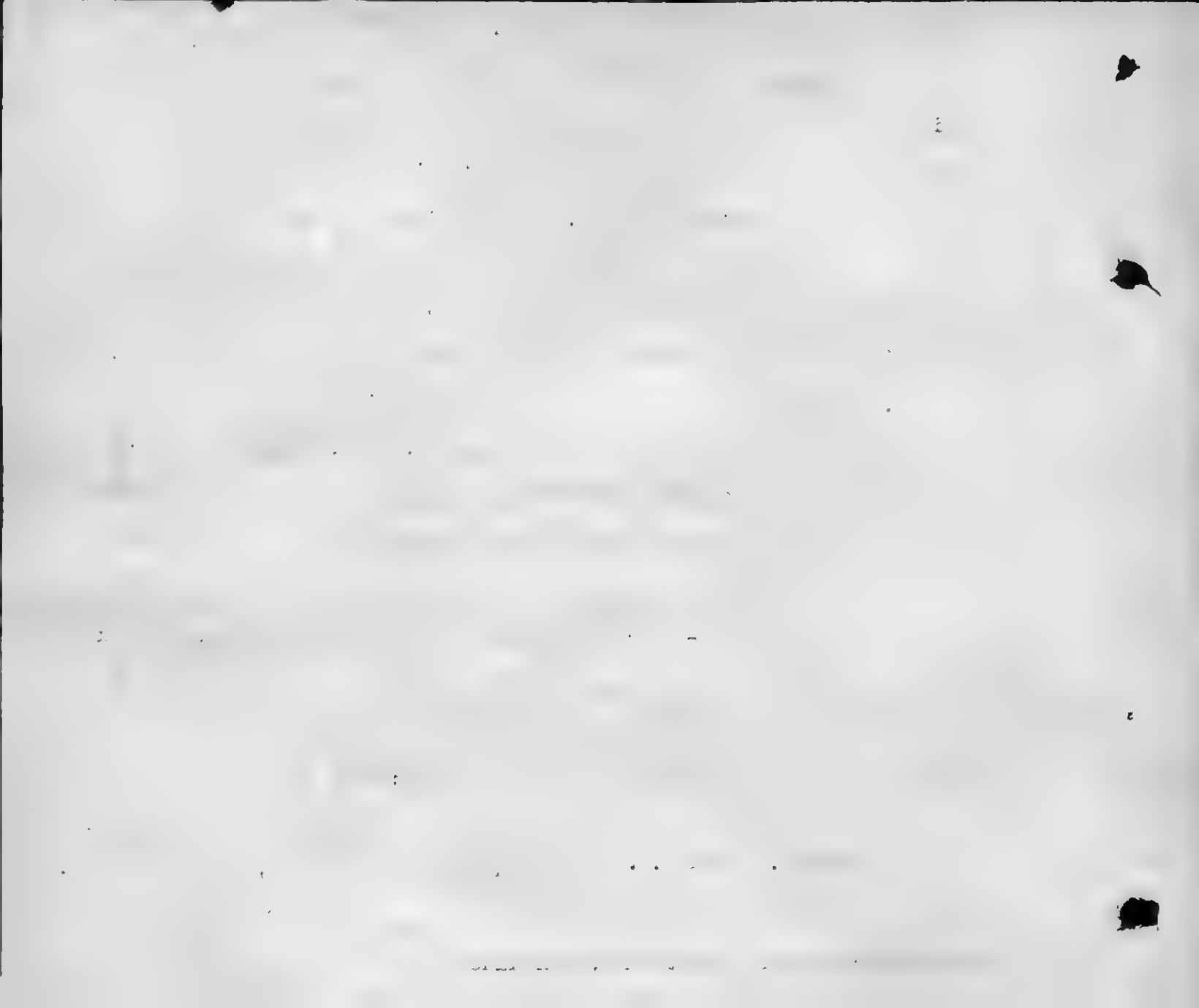
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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |   |  |   |  |   |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |
| 14216   |  |  |  |   |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery  |  | 14248  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>Maryland   |  | b. COUNTY<br>Prince Georges   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda  |  | c. LENGTH OF STAY IN IN-<br>stitution (If not in hospital, give street address)<br>63 days   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Hyattsville   |  | d. STREET ADDRESS<br>2609 Kirkwood Place  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>The Clinical Center, Bethesda 14, Md.   |  | First<br>Alice   |  | Middle<br>Dorothy   |  | Last<br>Walling   |  | 4. DATE OF DEATH<br>December 18 19 61   |  |
| 5. SEX<br>Female  |  | 6. COLOR OR RACE<br>White  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>December 4, 1916  |  | 9. AGE (in years) IF UNDER 1 YEAR<br>45 yrs. Months Days Hours M.n.                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Clerk-Typist   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Insurance   |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Virginia   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |
| 13. FATHER'S NAME<br>William W. Giles   |  | 14. MOTHER'S MAIDEN NAME<br>Gertrude Fields  |  |   |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) No   |  | 16. SOCIAL SECURITY NO.<br>218-20-2343   |  | 17. INFORMANT<br>The Medical Record<br>The Clinical Center, Bethesda 14, Maryland   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>DUE TO<br>(b)<br>DUE TO<br>(c)<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. |  | Aspiration pneumonia<br>Cerebral Embolus with brain damage                                   |  | INTERVAL BETWEEN ONSET AND DEATH<br>8 Hours<br>5 weeks  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>Rheumatic Heart Disease - Mitral Stenosis with left atrial thrombus  |  |  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m.<br>p.m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
| 20f. (City or town)   |  | (County)   |  | (State)   |  |   |  |   |  |
| 21. I certify that (this hospital) attended the deceased from October 16, 1961 to December 18, 1961, that (we) last saw the deceased alive on December 18, 1961, and that death occurred at 11:40 AM from the causes and on the date stated above.                  |  |  |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br>Paul A. Ebert   |  | M.D.   |  | 22b. ADDRESS<br>The Clinical Center, National Institutes of Health, Bethesda 14, Md.  |  | 22c. DATE<br>12/18/61   |  | 22d. SIGNATURE<br>Francis Gasch   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE THEREOF<br>12/21/61  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill  |  | 23d. LOCATION (City, town or county)<br>Suitland, Maryland  |  | (State)   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>Francis Gasch's Sons  |  | ADDRESS<br>Hyattsville, Maryland   |  | 25a. REC'D BY REGISTRAR<br>DATE DEC 21 '61  |  | 25b. REGISTRAR'S SIGNATURE<br>William S. Thomas   |  |   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14247

## CERTIFICATE OF DEATH

14217

| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MONTGOMERY COUNTY</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u><br>c. LENGTH OF STAY IN 1b <u>1 mo &amp; 13 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM &amp; HOSPITAL</u> |           |   |      | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>1234 DALE DRIVE</u> |  |                  |  |        |      |       |      |           |           |  |  |   |  |
|---|-----------|---|------|---|--|------------------|--|--------|------|-------|------|-----------|-----------|--|--|---|--|
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>LEONARD GRITTFITH WALLIS</u>   |           | <b>4. DATE OF DEATH</b><br>Month <u>12</u> Day <u>5</u> Year <u>1961</u>  |      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <b>5. SEX</b><br><u>MALE</u>  |           | <b>6. COLOR OR RACE</b><br><u>WHITE</u>   |      | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <b>8. DATE OF BIRTH</b><br><u>11-24-80</u>  |           | <b>9. AGE</b> (In years last birthday) <u>81</u> yrs. <table border="1" style="display: inline-table; font-size: 0.8em;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>11</u></td> <td><u>11</u></td> <td></td> <td></td> </tr> </table> |      | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS. |  | Months | Days | Hours | Min. | <u>11</u> | <u>11</u> |  |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>SOUTHERN RAILWAYS CO. RAILWAYS</u> |  |
| IF UNDER 1 YEAR   |           | IF UNDER 24 HRS.  |      |   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| Months  | Days      | Hours   | Min. |   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <u>11</u>   | <u>11</u> |   |      |   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>10. RAILWAYS</u>   |           | <b>11. BIRTH PLACE</b> (Country, State, and county)<br><u>Baltimore, Md., Montgomery County, U.S.A.</u>   |      | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>  |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <b>13. FATHER'S NAME</b><br><u>WILLIAM H. WALLIS</u>  |           | <b>14. MOTHER'S MAIDEN NAME</b><br><u>MARIA GRITTFITH</u>   |      |   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <u>NO</u>   |           | <b>16. SOCIAL SECURITY NO.</b><br><u>718-10-5746</u>  |      | <b>17. INFORMANT</b><br><u>HOSPITAL CHART</u>   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremia - Arteriosclerotic Heart Disease</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>4200</u><br>(a), stating the underlying cause last. DUE TO (c)                                 |           |   |      |   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Generalized Arteriosclerosis</u>  |           |   |      |   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |           |   |      |   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |           |   |      |   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |           |   |      |   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |           | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |      | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <b>20f. (City or town)</b>  |           | <b>(County)</b>   |      | <b>(State)</b>  |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>April, 1960</u> <b>to</b> <u>Dec. 5, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Dec. 4, 1961</u> , <b>and that death occurred at</b> <u>4:13 AM</u> <b>from the causes and on the date stated above.</b>   |           |   |      |   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <b>22a. SIGNATURE</b><br><u>J. Marion Bankhead</u> M.D.<br>b. PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>   |           | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/><br><b>22d. ADDRESS</b><br><u>9241 Col. Blvd. Silver Spring, Md.</u>  |      | <b>22b. DATE SIGNED</b><br><u>12/5/61</u>   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>BURIAL</u>   |           | <b>23b. DATE THEREOF</b><br><u>12/7/61</u>  |      | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>ROCK CREEK CEMETERY</u>   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <b>23d. LOCATION</b> (City, town or county)<br><u>WASHINGTON D.C.</u>   |           | <b>23e. REC'D BY REGISTRAR</b> <u>Raymond A. Ziska</u> <b>23f. REGISTRAR'S SIGNATURE</b> <u>Raymond A. Ziska</u>  |      |   |  |                  |  |        |      |       |      |           |           |  |  |   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Wm. E. Pughley Forward Home 8434 Georgia Ave. S.S., Md.</u>   |           |   |      |   |  |                  |  |        |      |       |      |           |           |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove person's papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

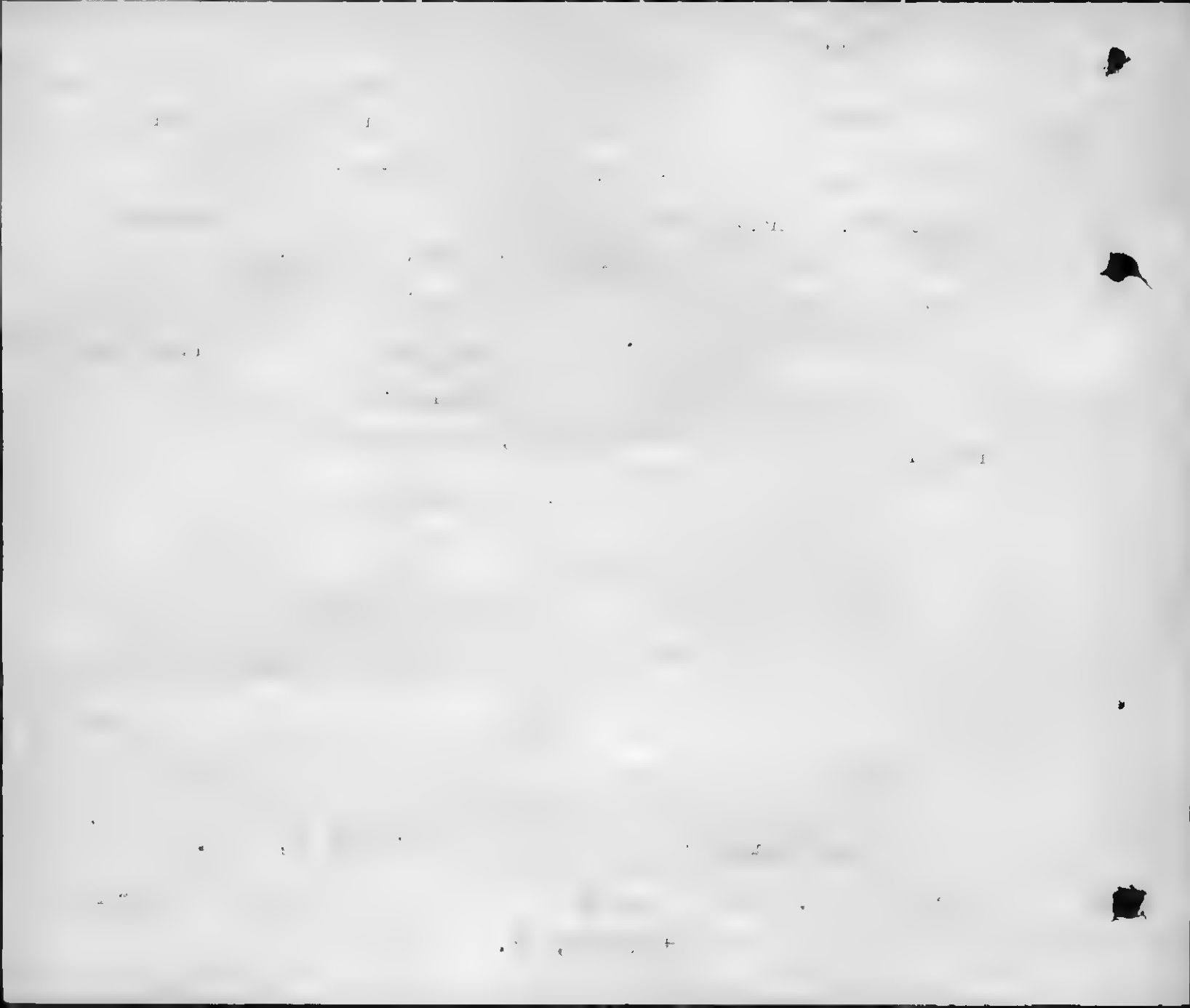
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15M 9/60

14248

14218

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Olney</b><br>c. LENGTH OF STAY IN lb<br><b>10 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)<br><b>Montgomery General Hospital</b>                             |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Gaithersburg</b><br>d. STREET ADDRESS<br><b>none</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Montgomery General Hospital</b><br>First Middle Last<br><b>Nona Burns Warthen</b>  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 24 19 61</b>  |  |
| 5. SEX<br><b>female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>8/19/1883</b>  |  |
| 9. AGE (In years last birthday)<br><b>78 yrs.</b>   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>homemaker</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 13. FATHER'S NAME<br><b>Clifford Burns</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Roseanna Glaze</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>unknown</b>  |  |
| 16. SOCIAL SECURITY NO.<br><b>217 28 6033</b>   |  | 17. INFORMANT<br><b>Hospital Records</b><br>Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Compression fracture T-9+12</b><br>(c) <b>10 days</b><br>DUE TO<br>(e), stating the underlying cause last. |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>10 days</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <b>Arteriosclerosis, Generalized</b>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>Patient fell out of bed, at home</b>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>12-14 1961</b><br>Hour a.m. p.m.  |  | 20d. INJURY OCCURRED<br>While Not While<br>at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)<br><b>Home</b>  |  | 20f. (City or town) (County) (State)<br><b>Gaithersburg Md.</b>   |  |
| 21. I certify that (I) (the hospital) attended the deceased from <b>Dec. 15, 1961</b> to <b>Dec. 24, 1961</b> , that (I) (we) last saw the deceased alive on <b>12-24-1961</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.   |  | 22a. SIGNATURE<br><b>Jack Schumacker</b> M.D.   |  |
| 22b. PHYSICIAN'S NAME (Type)<br><b>Jack Schumacker</b>  |  | 22c. ADDRESS<br><b>Gaithersburg, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>Dec. 28 1961</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Damascus</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Damascus Maryland</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Francis H. Barber</b><br>ADDRESS<br><b>Laytonville, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 29 '61</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Tins</b>   |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

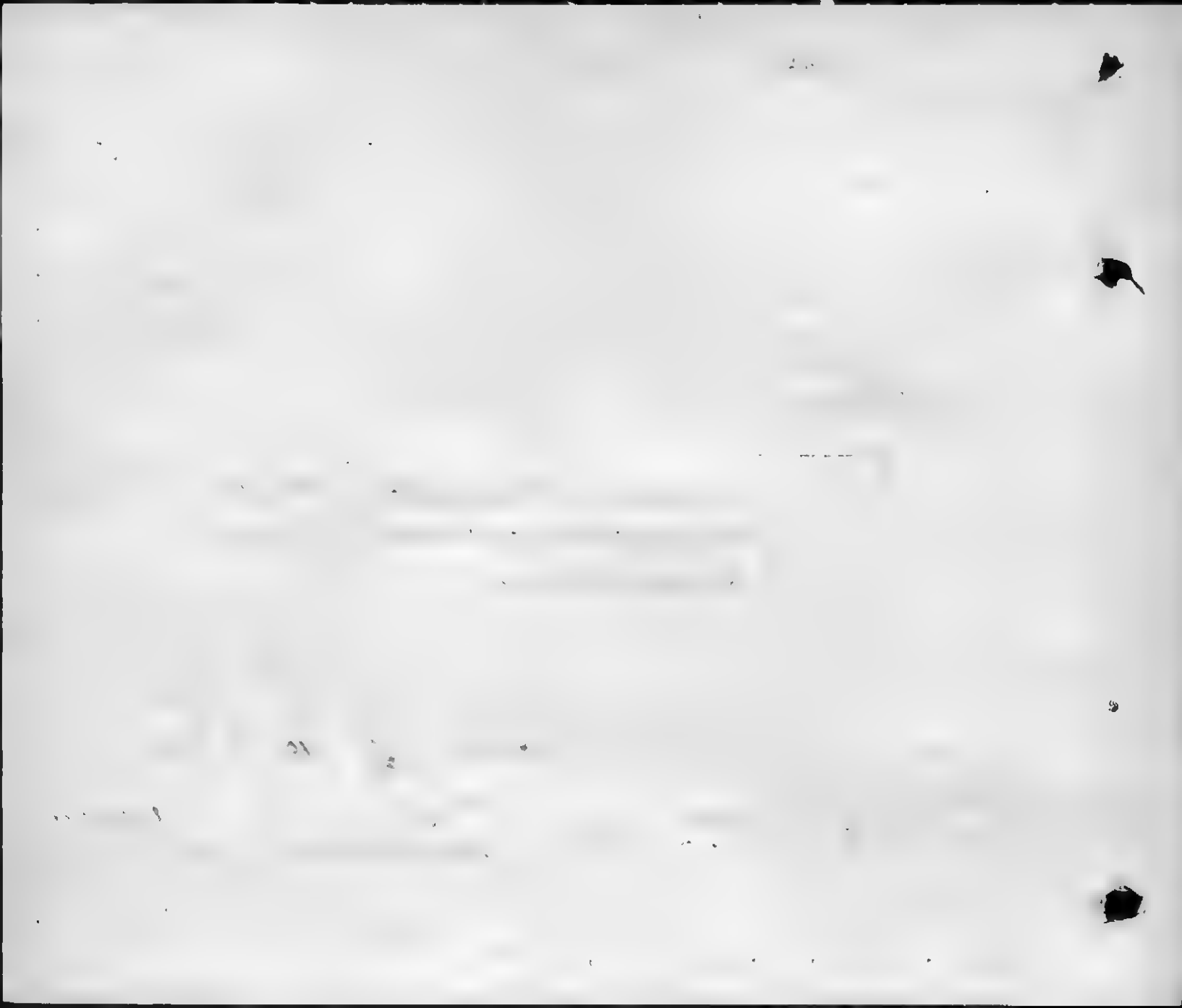
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14249

## CERTIFICATE OF DEATH

14219

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Prince Georges</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>c. LENGTH OF STAY IN <u>MD</u> |   |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Prince Georges</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>5058 Lincoln Rd</u>  |   |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Hillman</u> <u>Ellie</u> <u>Weaver</u>  |   |   | <b>4. DATE OF DEATH</b><br>Month <u>Dec</u> Day <u>12</u> Year <u>1961</u>  |   |   |
| <b>5. SEX</b><br><u>Female</u>   | <b>6. COLOR OR RACE</b><br><u>White</u> | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>8-16-1891</u>   | <b>9. AGE</b> (In years last birthday) <u>70</u> yrs. | <b>10. IF UNDER 1 YEAR</b><br>Months <u>70</u> Days <u>12</u> |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Retired Civil Service</u>   |   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>U.S. govt</u>  |   |   |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>North Carolina</u>  |   |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>  |   |   |
| <b>13. FATHER'S NAME</b><br><u>Newton</u>  |   |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Mary S Ben</u>  |   |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)<br><u>***</u>   |   |   | <b>16. SOCIAL SECURITY NO.</b><br><u>***</u>  |   |   |
| <b>17. INFORMANT</b><br><u>Hospital Records</u>  |   |   | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis Acute</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Heart Disease</u><br>(a), stating the underlying cause last. (c) <u>Hypertension</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 days</u> |   |   |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   | <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   |   |
| <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |   |   | <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <u>e.m.</u> <u>19</u>   |   |   |
| <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |   |   |
| <b>20f. (City or town)</b> (County) (State)  |   |   | <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>9-23-1961</u> , to <u>12-12-1961</u> , that (I) (we) last saw the deceased alive on <u>12-11-1961</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.  |   |   |
| <b>22a. SIGNATURE</b><br><u>Sam Hillman</u>  |   |   | <b>22b. DATE SIGNED</b><br><u>12/12/61</u>  |   |   |
| <b>22c. PHYSICIAN'S NAME</b> (Type) <u>SAMUEL A. HILLMAN</u>   |   |   | <b>22d. ADDRESS</b><br><u>8829 Flower Ave. S.S. Md</u>  |   |   |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>   |   |   | <b>23b. DATE THEREOF</b><br><u>12/15/61</u>   |   |   |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Fort Lincoln Cemetery</u>  |   |   | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Prince Georges Maryland</u>   |   |   |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Warner E. Pumphrey</u>   |   |   | <b>25a. REC'D BY REGISTRAR</b><br><u>DEC 15 '61</u>   |   |   |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>W. E. Pumphrey</u>   |   |   | <b>25c. REGISTRAR'S SIGNATURE</b><br><u>W. E. Pumphrey</u>  |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

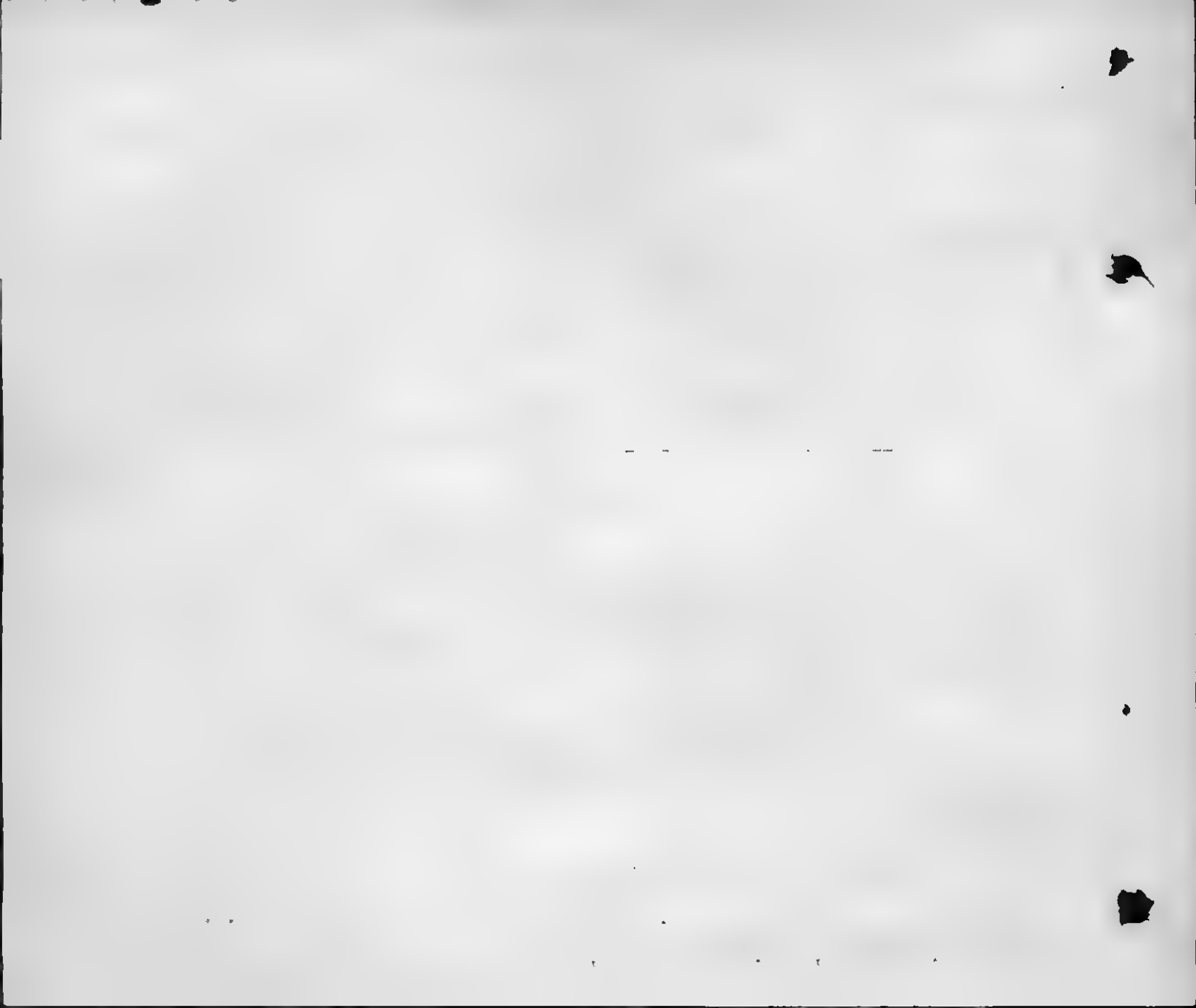
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14250

14220

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>         |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN b. <u>2 days</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1503 Ladd Street</u>   |  | d. STREET ADDRESS <u>8207 New Hampshire Ave</u>  |  |
| 3. NAME OF DECEASED (Type or print) <u>Alice Cecelia Welch</u>   |  | e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 5. SEX <u>Female</u>   |  | 4. DATE OF DEATH <u>Dec 11 1961</u>  |  |
| 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH <u>Nov 23, 1898</u>   |  | 9. AGE (In years last birthday) <u>63</u> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>William F. O'Beirne</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Teresa McDonald</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>220-32-6153</u>   |  |
| 17. INFORMANT <u>Alice Welch Mathewson</u>   |  | Address <u>1503 Ladd St. Silver Spring, Md.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE BRONCHOPNEUMONIA</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u></u><br>(c) <u></u><br>DUE TO<br>(e), stating the underlying cause last. (c) <u></u> |  | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)   |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (the hospital) attended the deceased from <u>Dec 11, 1961</u> to <u>Dec 11, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec 11, 1961</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE <u>Raymond Bradshaw</u>   |  | 22b. DATE SIGNED <u>Dec 11, 1961</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>   |  | 22d. ADDRESS <u>345 University Blvd W. Silver Spring, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>12/15/61</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>  |  | 23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Pumphrey</u>   |  | 25a. REC'D BY REGISTRAR <u>DEC 15 '61</u>  |  |
| Address <u>434 Georgia Avenue Silver Spring, Maryland</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

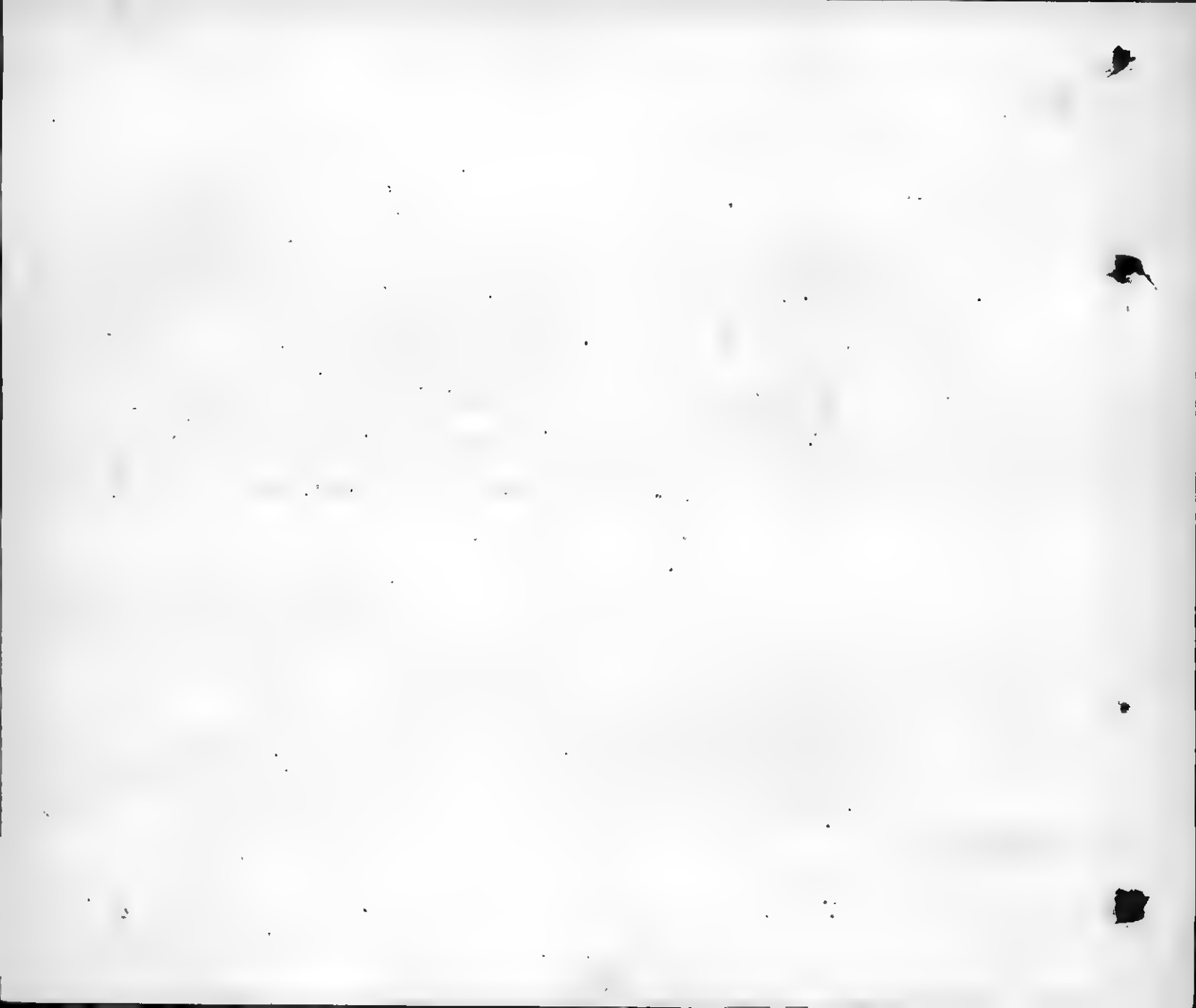
## CERTIFICATE OF DEATH

14221  
Reg. Dist. No.

|   |                                     |   |   |
|---|-------------------------------------|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |                                     | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>                       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ROCKESVILLE</u>  |                                     | c. LENGTH OF STAY IN 1b   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>RFD#2 DICKERSON, MD.</u>   |                                     | e. STREET ADDRESS<br><u>1 RFD#2</u>   |   |
| 3 NAME OF DECEASED (Type or print)<br>First <u>CLINTON</u> Middle <u>WELLS.</u> Last <u>WELLS.</u>  |                                     | 4. DATE OF DEATH<br>Month <u>DECEMBER</u> Day <u>5</u> Year <u>1961</u>   |   |
| 5. SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>NOV. 30, 1892</u>  |
| 9. AGE (In years last birthday)<br><u>69</u> yrs.   |                                     | 10. IF UNDER 1 YEAR<br>Months <u>6</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>   | 11. IF UNDER 24 HRS<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>AGRICULTURIST</u>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>AGRIC. DEPT</u>   | 11. BIRTHPLACE (State or foreign country)<br><u>WASHINGTON</u>                                    |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                     |   |   |
| 13. FATHER'S NAME<br><u>JAMES WELLS</u>   |                                     | 14. MOTHER'S MAIDEN NAME<br><u>EDITH SQUIRES</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>YES 18 DAYS</u>   |                                     | 16. SOCIAL SECURITY NO.<br><u>18 DAYS</u>   |   |
| 17. INFORMANT<br><u>ELIZABETH WELLS - DICKERSON, MD.</u>  |                                     | Address <u>RFD#2</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u><br><u>331X</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>cerebral arteriosclerosis</u><br>DUE TO<br>(c) <u>Arteriosclerosis</u> |                                     |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 hours</u><br><u>2 years</u><br><u>2 years</u>            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                     |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>19</u><br>p. m. <u>19</u>  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>1 Dec</u> , 19 <u>61</u> , to <u>6 Dec</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5 Dec</u> , 19 <u>61</u> , and that death occurred at <u>1 P.</u> M., from the causes and on the date stated above.   |                                     |   |   |
| ACTUAL SIGNATURE<br><u>John S. Fawcett</u> M.D.   |                                     | ADDRESS (Street, city or town, state)<br><u>Danville</u>  |   |
| PHYSICIAN'S NAME (Type)<br><u>P.O. BOYD, MARYLAND</u>   |                                     | DATE SIGNED<br><u>12/5/61</u>   |   |
| 22a. METHOD OF CREMATION<br>(Remove and Specify)  | 22b. DATE THEREOF<br><u>12/5/61</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Lee's</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Washington D.C.</u>                           |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Lee's Funeral Home 300-4647 N.E.</u>   |                                     | 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 7 '61</u>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><u>Charles S. Travis</u>  |                                     |   |   |

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

14252 Item 8 Film G302 12/8/61  
Item 2 Film G305 1/18/62

1. PLACE OF DEATH  
a. COUNTY **Montgomery**  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Bethesda**  
c. LENGTH OF STAY IN TB **9 days**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Suburban**

2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
a. COUNTY **Montgomery**  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Kensington Bethesda**  
c. STREET ADDRESS **2201 Old Georgetown Town**  
d. **Lebanon Gardens, Md.**

3. NAME OF DECEASED (Type or print)  
First **Harriet** Middle **Wentworth** Last **Wentworth**

4. DATE OF DEATH **December 3, 1961**

5. SEX **Female**

6. COLOR OR RACE **White**

7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH **9/16/1874**

8. WIDOWED ☒ D. DIVORCED ☐

9. AGE (In years, last birthday) **87 yrs.**

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Homemaker**

11. BIRTHPLACE (County & State, or foreign country) **Mass.**

12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Fairchild**

14. MOTHER'S MAIDEN NAME **NOT AVAILABLE**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No**

16. SOCIAL SECURITY NO. **153-1**

17. INFORMANT **(daughter-in-law)**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Starvation**  
DUE TO **Carcinoma of transverse colon**  
CONDITIONS, if any, which gave rise to immediate cause (b) **unknown**  
(c) **unknown**

19. WAS AUTOPSY PERFORMED? **NO**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **unknown**

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year **11/25/1961**

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **10620 Georgia Ave. Silver Spring, Md.**

20f. (City or town) **Silver Spring, Md.**

20g. (County) **Montgomery**

20h. (State) **Md.**

21. I certify that (I) (this hospital) attended the deceased from **11/25/61** to **12/3/61** that (I) (we) last saw the deceased alive on **12/3/61** and that death occurred at **8:00 P.M.** from the causes and on the date stated above.

22a. SIGNATURE **Wm Y. Marcus**

22b. DATE SIGNED **12/3/61**

22c. PHYSICIAN'S NAME (Type) **Wm Y. Marcus**

22d. ADDRESS **10620 Georgia Ave. Silver Spring, Md.**

22e. (City or town) **Silver Spring, Md.**

22f. (County) **Montgomery**

22g. (State) **Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Cremation**

23b. DATE THEREOF **12/5/61**

23c. NAME OF CEMETERY OR CREMATORY **Wheaton Cemetery**

23d. LOCATION (City, town or county) **Bladensburg, Maryland**

23e. (State) **Md.**

24. FUNERAL DIRECTOR'S SIGNATURE **Arthur Walters**

24a. ADDRESS **254 Carroll St., N.W.**

24b. REC'D BY REGISTRAR **DEC 6 '61**

24c. REGISTRAR'S SIGNATURE **Arthur S. Thomas**

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**MARYLAND STATE DEPARTMENT OF HEALTH**

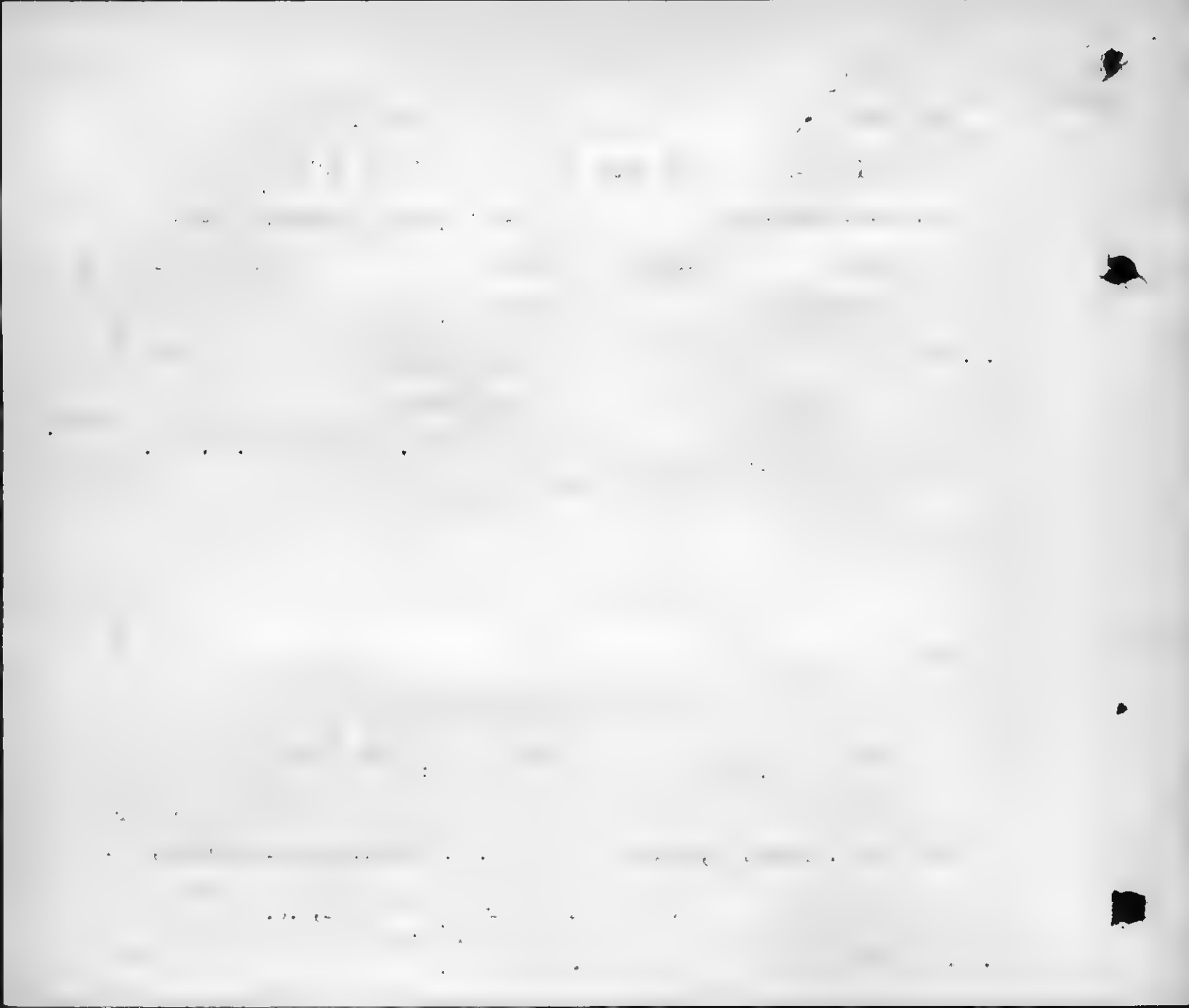
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

14253

## CERTIFICATE OF DEATH

14223

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. PLACE OF BIRTH<br>a. COUNTY<br><b>Montgomery</b>  |  | MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b>   |  | c. LENGTH OF STAY IN lb<br><b>83 days</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>U.S. Naval Hospital</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>  |  | b. COUNTY<br><b>Montgomery</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Luke</b>  |  | 4. DATE OF DEATH<br>Month<br><b>December</b>  |  | Day<br><b>31</b>  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Caucasian</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  |
| 8. DATE OF BIRTH<br><b>23 April 1937</b>   |  | 9. AGE (In years last birthday)<br><b>24</b>  |  | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>New Jersey</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 13. FATHER'S NAME<br><b>David Irvine WHITE</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Mary FORBES</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give year or dates of service)<br><b>Yes</b>  |  | 16. SOCIAL SECURITY NO.<br><b>199-1-1991</b>  |  |
| 17. INFORMANT<br><b>(Wife) Jeanne A. WHITE</b>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic carcinoma</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____ |  | 19. INTERVAL BETWEEN ONSET AND DEATH<br><b>14 mos.</b>  |  |
| 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)<br><b>20a. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]<br><b>20c. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>20e. (City or town)</b> _____ (County) _____ (State) _____ |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Sept. 9, 1961</b> to <b>Dec. 31, 1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 31, 1961</b> , and that death occurred at <b>1:15 A.M.</b> from the causes and on the date stated above. |  | 22a. SIGNATURE<br><b>William P. Urschel</b> M.D.  |  | 22b. DATE<br><b>December 31, 1961</b>   |  |
| 22c. PHYSICIAN'S NAME<br><b>William P. URSHEL LT, MC, USN</b>  |  | 22d. ADDRESS<br><b>U. S. Naval Hospital Bethesda, Md.</b>   |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Shipment</b>  |  |
| 23b. DATE THEREOF<br><b>1-8-62</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rosedale Crematory</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Orange, N.J.</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>R. A. Pumphrey</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 3 '62</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Clarence S. Hanna</b>  |  |



STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14254 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN 1b <u>Days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. N.V.L. HOSPITAL</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Res. concerned, give institution)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>d. STREET ADDRESS <u>207 Adelaide Court</u> |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>Delbert</u> <u>Swan</u> <u>Wicks</u>  |  | 4. DATE OF DEATH<br>Month Day Year<br><u>December</u> <u>17</u> <u>1961</u>                               |  | 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>Caucasian</u>   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><u>July 17, 1911</u>  |  | 9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS.<br><u>50</u> yrs. Months Days Hours Min.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. NAVY</u> |  |
| 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country) <u>Providence, R. I.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  | 13. FATHER'S NAME <u>Delbert Samuel Wicks</u>  |  |
| 14. MOTHER'S MAIDEN NAME <u>Anna Arnold</u>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>                              |  | 16. SOCIAL SECURITY NO. <u>(Wife)</u>   |  | 17. INFORMANT <u>Elcie R. Wicks</u> Address <u>207 Adelaide Ct., Bethesda, Md.</u>                           |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br><u>420.1</u> DUE TO <u>Coronary Occlusion</u><br>Conditions, if any, which gave rise to immediate cause (b) _____<br>(a), stating the underlying cause last. DUE TO (c) _____   |  |   |  |   |  |  |  |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18.)              |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <u>Frank G. Broschart</u>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) <u>Frank G. Broschart</u>  |  | DATE SIGNED <u>13 December 1961</u>   |  | Address (Street, city, town, or county)   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>12-13-61</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Highland Memorial Park</u>  |  | 22d. LOCATION (City, town, or country) (State) <u>providence, R.I.</u>                                       |  |
| 23. FUNERAL DIRECTOR <u>W.W. Chambers</u>   |  | 24a. REC'D BY REGISTRAR <u>121 '61</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>W. L. Jones</u>   |  |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

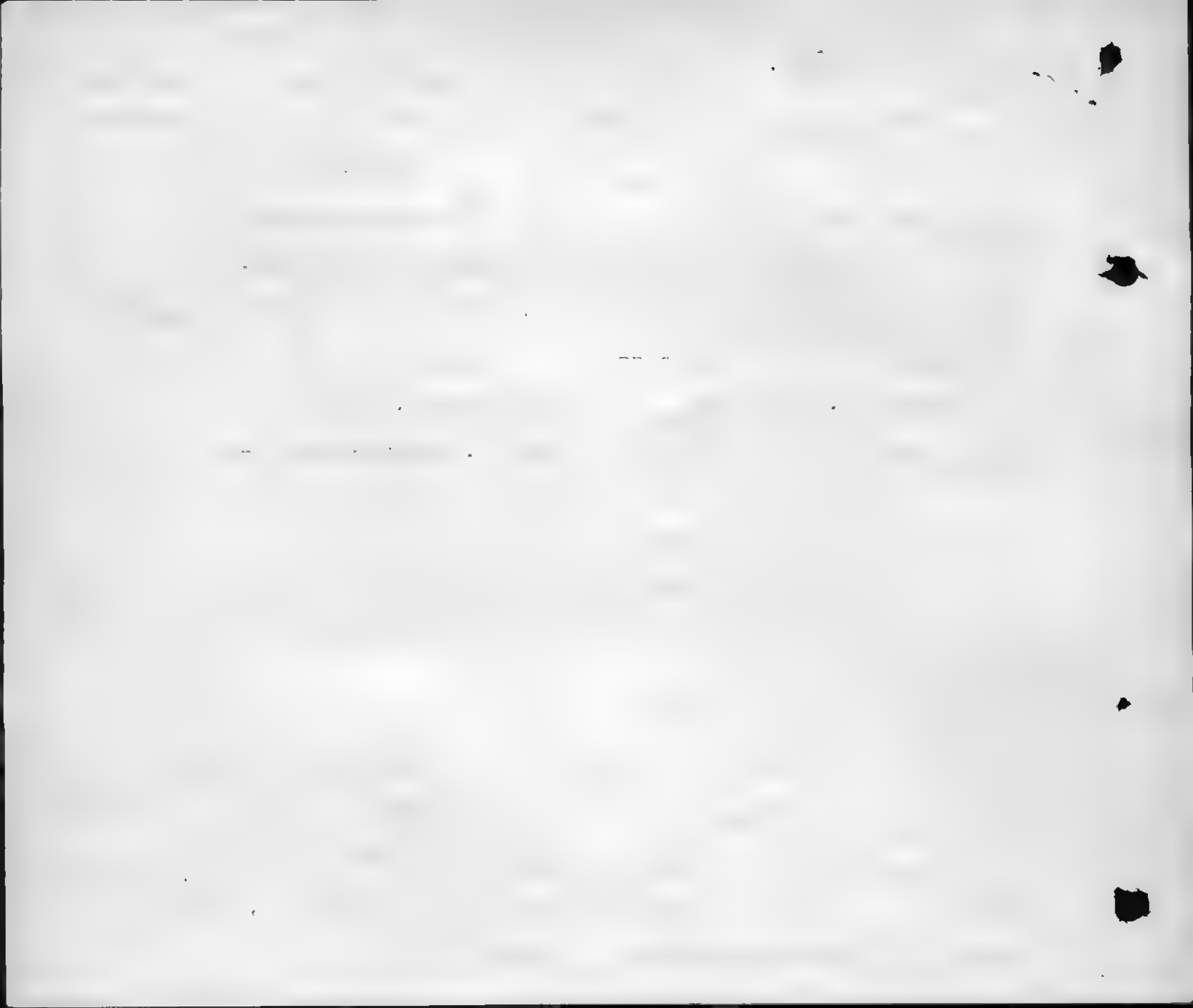
## CERTIFICATE OF DEATH

14255

Item 16 R-1-M-3305 1/22/62 iwk

14225

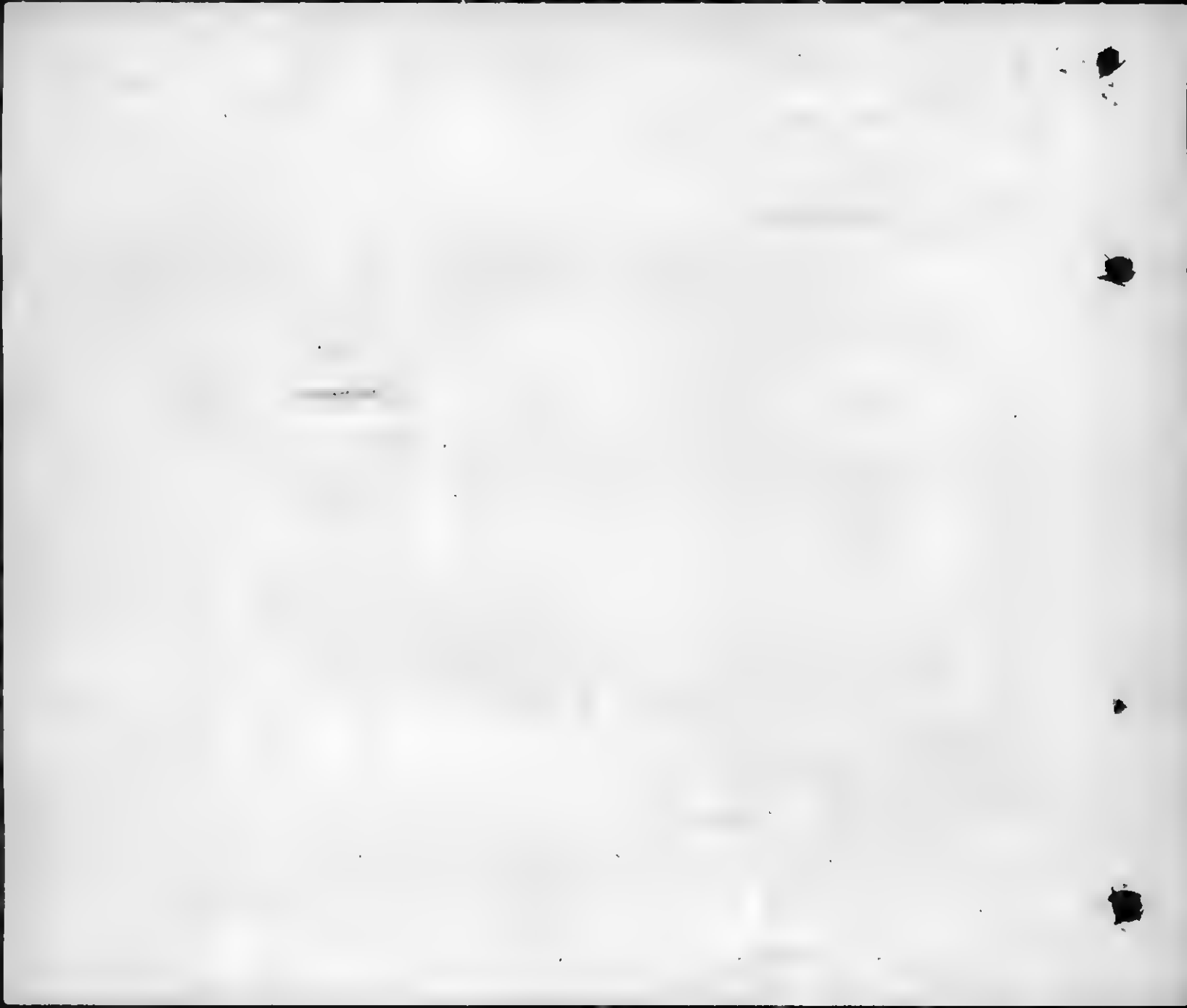
|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>5833 Osceola Court</b>  |  | d. STREET ADDRESS<br><b>5833 Osceola Court</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ione</b> Middle <b>Elizabeth</b> Last <b>Wiekler</b>   |  | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>20</b> Year <b>19 61</b>   |  |
| 5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>7/25/1912</b>   |  | 9. AGE (In years last birthday) <b>49</b> yrs <b>4</b> months <b>25</b> days <b>25</b> hours <b>0</b> min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b> 11. BIRTHPLACE (County & State, or foreign country)<br><b>Iowa</b>   |  |
| 13. FATHER'S NAME<br><b>Thomas C. Anderson</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Lura M. Matteson</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown, (If yes give year or dates of service))<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>556-07-9669</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b><br>DUE TO <b>Portal Hypertension</b><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>Metastatic Carcinoma Liver (Primary Rectum)</b><br>DUE TO <b>Metastatic Carcinoma Liver (Primary Rectum)</b> |  | 17. INFORMANT<br><b>John L. Wiekler-Husband-same 2d</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 1960</b> to <b>Dec. 20, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 19, 1961</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE<br><b>Clifton R. Gruver</b>   |  | 22b. DATE (SIGNED)<br><b>12/20/61</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Clifton R. Gruver</b>   |  | 22d. ADDRESS<br><b>915 19th St. N.W. Wash D.C.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>12/22/61</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Rockville, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 22 '61</b>   |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Clifton R. Gruver</b>  |  |



VR A15 (4)  
ISM 9/59

## 14256

|   |                                  |   |                                    |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. COUNTY<br><b>Maryland</b>                                       |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>5320 Yorktown Road</b>   |                                  | d. STREET ADDRESS<br><b>5320 Yorktown Road</b>  |                                    |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>ORIS BENTON WILLIAMS</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Dec</b> Day <b>3</b> Year <b>1961</b>  |                                    |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/27/12</b> |
| 9. AGE (In years last birthday)<br><b>49</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>6</b> Hours <b></b> Min. <b></b>   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b>   |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                    |
| 13. FATHER'S NAME<br><b>James McKee Williams</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Emma J. Grimson</b>  |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>023-03-4840</b>   |                                    |
| 17. INFORMANT<br><b>Joyce M. Williams, Wife-same 2d</b>   |                                  | Address<br><b></b>  |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY ARTERY DISEASE</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>YEARS</b>  |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <b>19</b><br>p. m. <b></b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov 7</b> , 19 <b>61</b> , to <b>Dec 3</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Nov 7</b> , 19 <b>61</b> , and that death occurred at <b>6:53 P</b> M, from the causes and on the date stated above.                   |                                  |   |                                    |
| 22a. SIGNATURE<br><b>DeWitt E. DeLawter</b>   |                                  | 22b. DATE SIGNED<br><b>12-3-61</b>  |                                    |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DEWITT E. DELAWTER</b>   |                                  | 22d. ADDRESS<br><b>8025 ABERDEEN RD. Bethesda 14, Md</b>  |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>12/6/61</b>   |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Cemetery</b>   |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Arlington, Virginia</b>   |                                    |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey, Bethesda, Maryland</b>   |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 6 '61</b>  |                                    |
| 25b. REGISTRAR'S SIGNATURE<br><b>Carroll P. Pumphrey</b>  |                                  |   |                                    |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

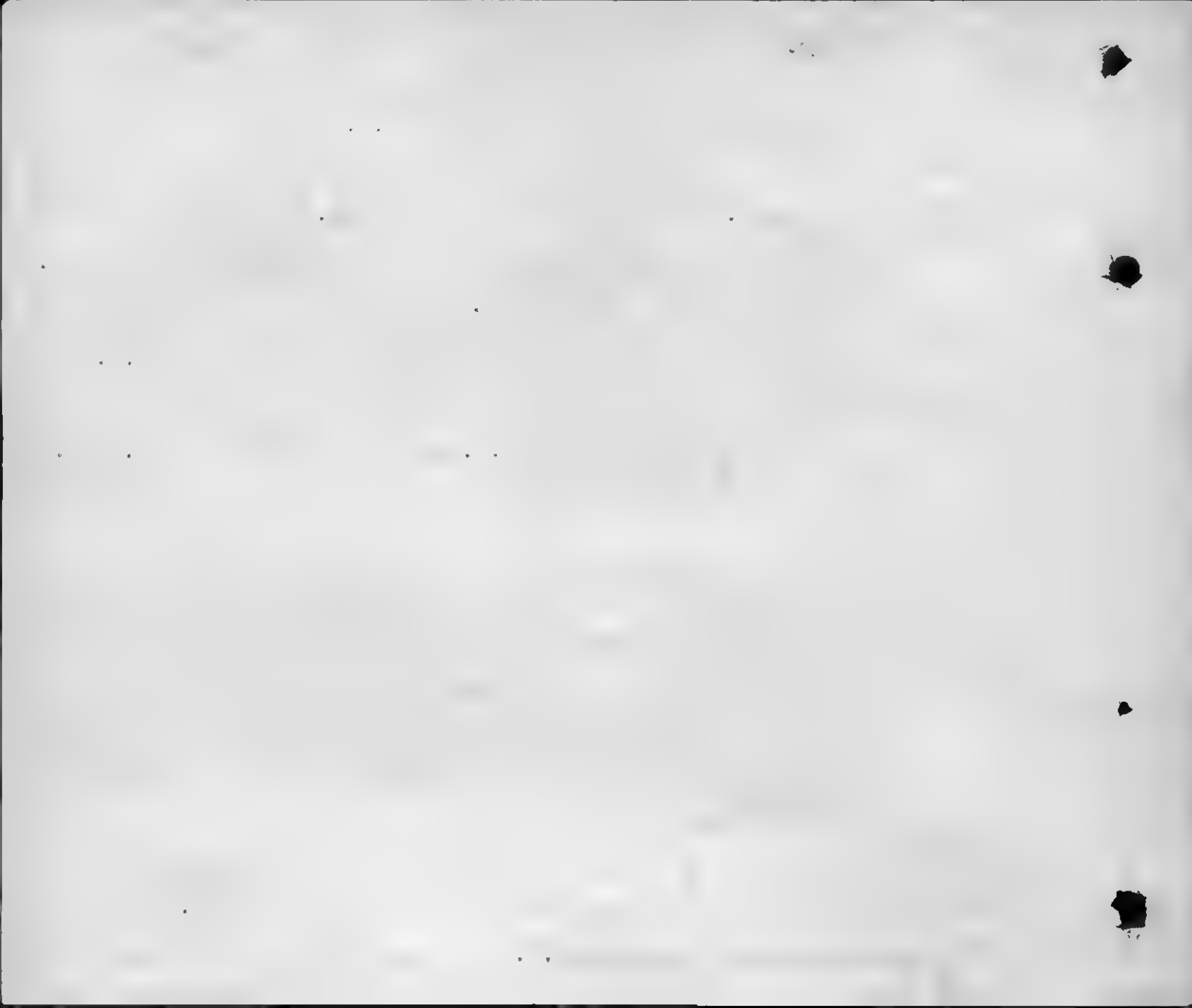
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

14257  
14227

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

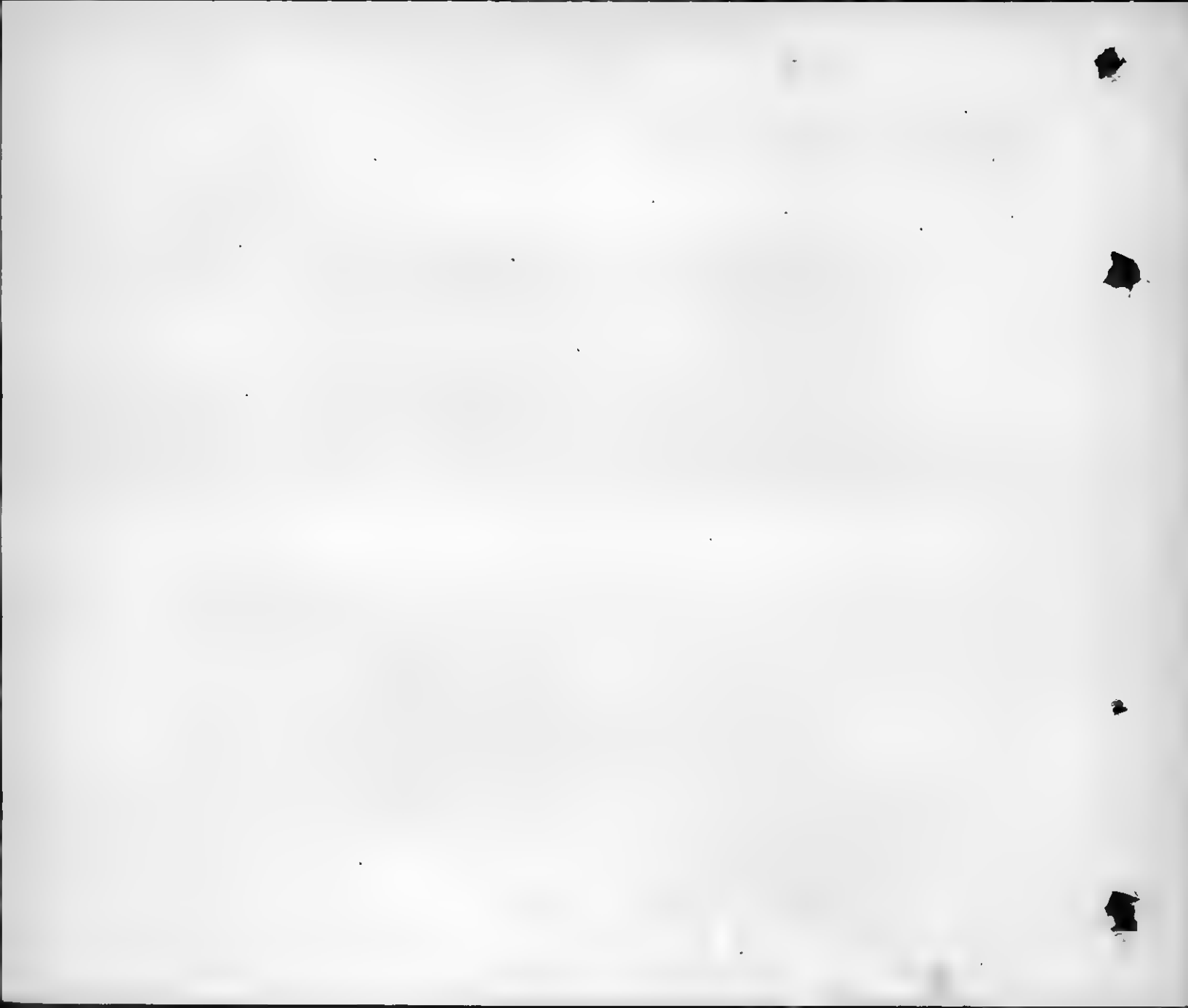
|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Cedar Croft N Home.</u>  |  | d. STREET ADDRESS<br><u>5811 - 6th. St N.W.</u>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Mae</u> First <u>F</u> Middle <u>Wilson</u> Last <u>Wilson</u>  |  | 4. DATE OF DEATH <u>December 19</u> 19 <u>61</u> .<br>Month <u>Dec.</u> Day <u>17</u> Year <u>1879</u>   |  |
| 5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>Dec. 17, 1879</u> AGE (in years) <u>81</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>81</u> Days <u>17</u> Hours <u>17</u> M n. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Ohio</u>   |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |  |
| 13. FATHER'S NAME<br><u>George A Frey</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Rudy</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>None</u>  |  | 17. INFORMANT<br><u>Mrs H.L. Matthias - 5811 - 6th St. D.C.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Labor Pneumonia</u><br>DUE TO <u>1470 X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO <u>1470 X</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).<br><u>Arteriosclerotic cardiovascular disease</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 d</u>   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)<br><u>None</u>   |  |
| 20c. TIME OF INJURY<br>Hour <u>19</u> a.m. <u>19</u> p.m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>None</u>   |  | 20f. (City or town) (County) (State)<br><u>Washington D.C.</u>   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>55</u> , to <u>Dec. 19</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Dec. 8</u> 19 <u>61</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE<br><u>M. F. Ottman</u>   |  | 22b. DATE SIGNED<br><u>Dec. 19 1961</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>M. F. OTTMAN</u>   |  | 22d. ADDRESS<br><u>401 Kennedy St NW</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>   |  | 23b. DATE THEREOF<br><u>12-12-61</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Leet's Crematorium</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Washington D.C.</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Lee F. Funeral Home - Washington D.C.</u>  |  | 25a. REC'D BY REGISTRAR<br><u>DEC 13 '61</u>   |  |
| ADDRESS<br><u>Lee F. Funeral Home - Washington D.C.</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles S. Howard</u>   |  |



14258  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
14228

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Md</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium &amp; Hospital</b>   |  |   |  | d. STREET ADDRESS <b>95 E. Wayne Avenue</b>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Stella Windish</b>  |  |   |  | 4. DATE OF DEATH <b>12 30 1961</b>   |  |  |  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>Oct. 22, 1878</b>  |  |
| 9. AGE (In years last birthday) <b>83</b> yrs  |  | IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min</b>   |  | IF UNDER 24 HRS <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min</b>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Sharon Park Hotel</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Penna</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |  |  |  |  |  |
| 13. FATHER'S NAME <b>Thomas Jones</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Hannah Everett</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO (If yes, give war/air dates of service) <b>577-10-2508A</b>                                      |  | 17. INFORMANT <b>Mr. James F. Lloyd</b>  |  | Address <b>(Same as #2)</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO <b>Ventricular Fibrillation</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO (b) <b>Myocardial Infarction</b><br>DUE TO (c) <b>Myocardial Infarction</b> |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Infarction</b>   |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)                             |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov 29, 1961</b> to <b>Dec 30, 1961</b> , that (I) (we) lost the deceased alive on <b>12/30/1961</b> , and that death occurred at <b>11:50 a.m.</b> from the causes and on the date stated above.   |  |   |  |  |  |  |  |
| 22a. SIGNATURE <b>Robert R. Hottel</b> M.D.  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22b. DATE SIGNED <b>12/30/61</b>   |  |
| 22c. PHYSICIAN'S NAME (Type, <b>Robert R. Hottel</b> )   |  |   |  | 22d. ADDRESS <b>1222 Monroe St NW</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE THEREOF <b>Jan. 2, 1962</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State) <b>Prince Geo. Co. Maryland</b>                  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters</b>  |  |   |  | ADDRESS <b>254 Carroll St NW. DC</b>   |  | 25a. REC'D BY REGISTRAR <b>JAN 3 '62</b>   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>W. S. J. J. J.</b>   |  |  |  |

be retained by the hospital or attending physician.  
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

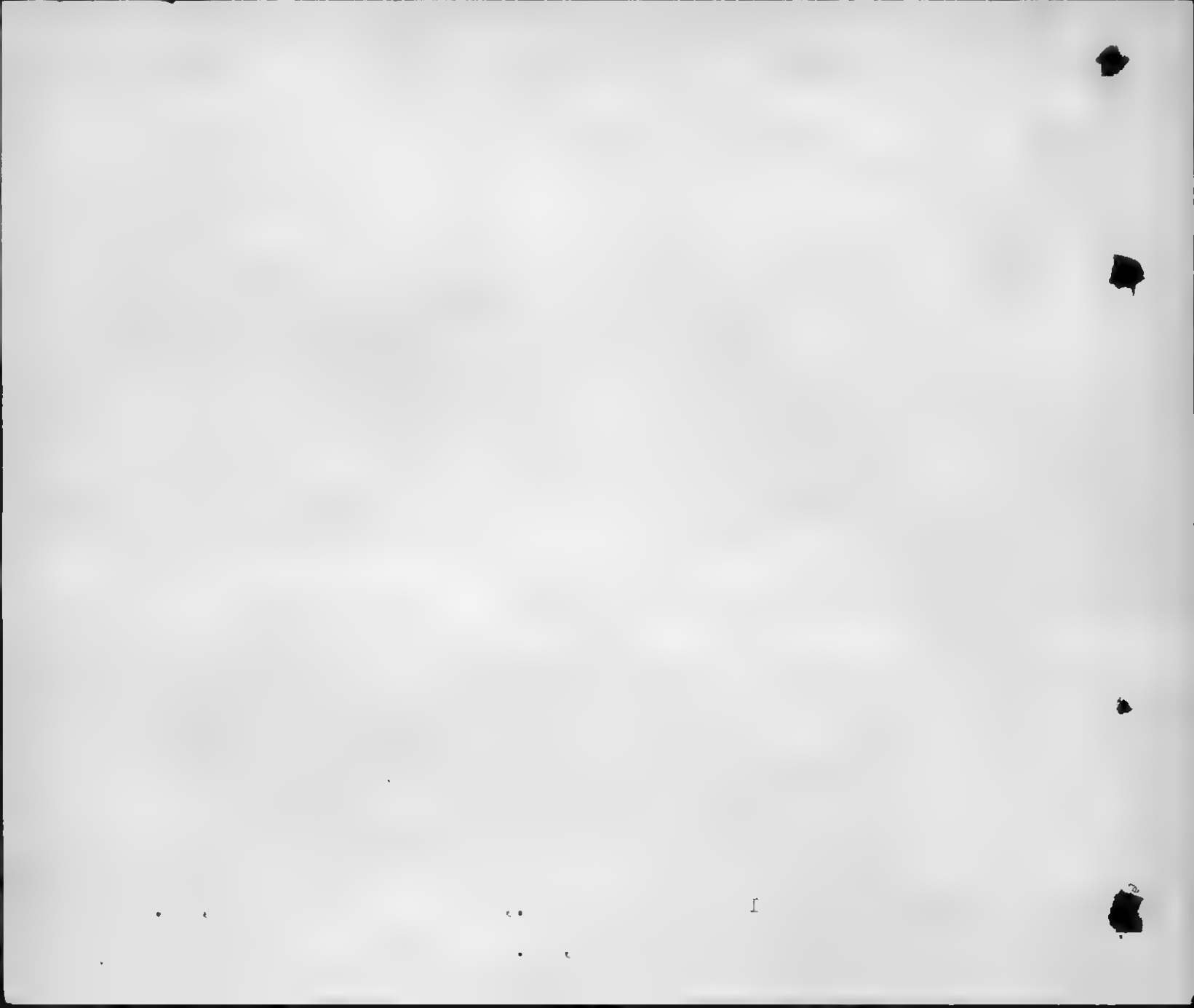
14259

## CERTIFICATE OF DEATH

14229

| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u><br>c. LENGTH OF STAY IN b. <u>24 day</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>  |                                     |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutions; Residence before admission)<br>a. STATE <u>Md.</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring Md.</u><br>d. STREET ADDRESS <u>Box 271 - Brook Road</u> |        |      |       |      |  |  |  |  |   |
|--|-------------------------------------|--|---|--|--------|------|-------|------|--|--|--|--|---|
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Margaret W. Wise</u>  |                                     | <b>4. DATE OF DEATH</b><br>Month <u>Dec</u> Day <u>5</u> Year <u>1961</u>  |   | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |        |      |       |      |  |  |  |  |   |
| <b>5. SEX</b><br><u>M</u>  | <b>6. COLOR OR RACE</b><br><u>C</u> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>8-14-25</u> | <b>9. AGE</b> (In years last birthday) <u>36</u> yrs. <table border="1"> <tr> <th>Months</th> <th>Days</th> <th>Hours</th> <th>Min.</th> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>   | Months | Days | Hours | Min. |  |  |  |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Custodian</u> |
| Months   | Days                                | Hours  | Min.                                      |  |        |      |       |      |  |  |  |  |   |
|  |                                     |  |   |  |        |      |       |      |  |  |  |  |   |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Ya.</u>   |                                     | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>   |   |  |        |      |       |      |  |  |  |  |   |
| <b>13. FATHER'S NAME</b><br><u>William Wise</u>  |                                     | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Unknown</u>  |   |  |        |      |       |      |  |  |  |  |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <u>Yes</u> <u>W.W.II</u>   |                                     | <b>16. SOCIAL SECURITY NO</b><br><u>Wise</u>   |   | <b>17. INFORMANT</b><br><u>Hattie Wise</u> Address <u>Silver Spring RT. 2 Good Hope Rd.</u>  |        |      |       |      |  |  |  |  |   |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hepatic failure</u><br>(b) <u>Obstructive jaundice</u><br>(c) <u>Recurrent carcinoma of stomach</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                     |  |   |  |        |      |       |      |  |  |  |  |   |
| <b>19. INTERVAL BETWEEN ONSET AND DEATH</b><br><u>3 days 6 weeks 2 yrs</u>   |                                     |  |   |  |        |      |       |      |  |  |  |  |   |
| <b>20. MEDICAL CERTIFICATION</b><br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)<br>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)<br>20f. (City or town) (County) (State) |                                     |  |   |  |        |      |       |      |  |  |  |  |   |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec 1 1961</u> <b>to</b> <u>Dec 5 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Dec 5 1961</u> <b>and that death occurred at</b> <u>7 M.</u> <b>from the causes and on the date stated above.</b>  |                                     |  |   |  |        |      |       |      |  |  |  |  |   |
| <b>22a. SIGNATURE</b><br><u>Robert L. Snowden</u>  |                                     | <b>22b. DATE SIGNED</b><br><u>12/5/61</u>  |   | <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Robert L. Snowden</u>  |        |      |       |      |  |  |  |  |   |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> <u>Burial</u>   |                                     | <b>23b. DATE THEREOF</b><br><u>12/9/61</u>   |   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Sandy Spring,,</u>   |        |      |       |      |  |  |  |  |   |
| <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Sandy Spring, Md.</u>  |                                     | <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>  |   |  |        |      |       |      |  |  |  |  |   |
| <b>25a. REC'D BY REGISTRAR</b><br>DATE <u>DEC 11 '61</u>   |                                     | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur E. Kraus</u>  |   |  |        |      |       |      |  |  |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and safely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |  |  |   |  |   |  |
|---|--|---|--|---|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |   |  |  |  |   |  |   |  |
| 14250 Items 3 & 10b, Film 0306 2/5/62 ink   |  |   |  |   |  |  |  |   |  |   |  |
| 14230   |  |   |  |   |  |  |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>Washington</u>      |  |  |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park</u>  |  |   |  | c. LENGTH OF STAY IN 1b<br><u>4 days</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Washington</u> |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Washington San + Hospital</u>  |  |   |  | d. STREET ADDRESS<br><u>5732 2nd St. N.E.</u>   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Anna</u> Middle <u>Laurie</u> Last <u>Wyke (Gilchrist)</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>Dec</u> Day <u>26</u> Year <u>1961</u>   |  |  |  |   |  |   |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>3-30-97</u>                                       |  | 9. AGE (In years last birthday)<br><u>64 yrs.</u>   |  | IF UNDER 1 YEAR<br>Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Clerk</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>N.S.A. (National Security Agency)</u>   |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>West Virginia</u>                           |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>                              |  |
| 13. FATHER'S NAME<br><u>Daniel N. Gilchrist</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Betsy Ann Wigal</u>  |  |  |  | Address <u></u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>  |  |   |  | 16. SOCIAL SECURITY NO.<br><u>246-12-3174</u>   |  | 17. INFORMANT<br><u>Mr. Betty Everley 4804</u><br>Address <u></u>        |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>157 X</u> DUE TO <u>Manitoba weakness, Ecolyca</u><br>Conditions, if any, which gave rise to immediate cause (b) <u>Excess of the Dances</u><br>(c) <u></u> DUE TO <u></u><br>causing the underlying cause last. |  |   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>9 months</u>   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                     |  |   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/22/61</u> , 19 <u>61</u> to <u>12/26/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> , 19 <u>61</u> , and that death occurred at <u></u> M, from the causes and on the date stated above.   |  |   |  |   |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><u>Charles Wolchon</u>  |  |   |  | 22b. DATE SIGNED<br><u>12/26/61</u>   |  | 22c. PHYSICIAN'S NAME (Type)<br><u>Charles Wolchon</u>                   |  | 22d. ADDRESS<br><u></u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF<br><u>12/28/1961</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Ft Lincoln</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Colmer Manor, Md.</u> |  |   |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Francis Hasch Sons</u>   |  |   |  | ADDRESS<br><u>Hyattsville, Md</u>   |  | 25a. REC'D BY REGISTRAR<br><u>JAN 2 '62</u>                              |  | 25b. REGISTRAR'S SIGNATURE<br><u>Walter S. Hume</u>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14261

## CERTIFICATE OF DEATH

14231

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Wheaton</b><br>c. LENGTH OF STAY IN b<br><b>19 da</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Wheaton Nursing Home</b>  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>D.C.</b><br>b. COUNTY<br><b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>478-3</b><br>d. STREET ADDRESS<br><b>742 Van Buren St. N.W.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Naomi R. YOPPS</b>   |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>Dec. 31, 1961</b>  |  |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 7, 1881</b>  | 9. AGE (In years last birthday)<br><b>80 yrs.</b>                      | IF UNDER 1 YEAR<br>Months Days<br><b>80</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |                                  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Washington, D.C.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>James Garner</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Louisa Weaver</b>  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |                                  |   | 16. SOCIAL SECURITY NO.<br><b>no</b>  |  |   |
| 17. INFORMANT<br><b>Otto E. Yopps</b>   |                                  |   | Address<br><b>742 VanBuren St. N.W.</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac failure</b><br>DUE TO (b) <b>Cardio-Vascular-Renal Disease</b><br>DUE TO (c) <b>Senility - Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  |   |   |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):<br><b>Senility - Arteriosclerosis</b>  |                                  |   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |   |  |   |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                  |   |   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>P.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
| 20f. (City or town) (County) (State)  |                                  |   |   |  |   |
| 21. I certify that (I) (the hospital) attended the deceased from <b>Nov. 1, 1961</b> to <b>Dec. 31, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 30, 1961</b> , and that death occurred <b>Dec. 31, 1961</b> from the causes and on the date stated above.   |                                  |   |   |  |   |
| 22a. SIGNATURE<br><b>Lynwood Heiges</b>   |                                  |   | 22b. DATE SIGNED<br><b>12/31/61</b>   |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>LYNWOOD HEIGES, MD, FACA</b>   |                                  |   | 22d. ADDRESS<br><b>4940 Piney Branch Road N.W., Washington 12, D.C.</b>   |  |   |
| 23a. BURIAL, CREMATION, or other disposition of body<br><b>burial</b>   |                                  | 23b. DATE THEREOF<br><b>1/2/62</b>  |   | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Ft. Lincoln Cemetery</b>    |   |
| 23d. LOCATION (City, town or county) (State)<br><b>Pr. Geo. Co., Maryland</b>   |                                  | 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>The J.D. Hines Co.</b>   |   |  |   |
| 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 3 '62</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>  |   |  |   |



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LYNWOOD HEESE, M.D. F.A.C.A.

8910 Park Road, N.W.

Washington, D.C.

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